PHYSICIANS CARE GROUP OF WEST GEORGIA, PC

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This is a request that Physicians Care Group of West Georgia:

☐ Send Information or ☐ Obtain information on behalf of:

Patient information:

Name:_____ Age:___DOB:___ SS#:_____

Address:_____ City:_____ State: ____ Zip:_____

Who has the information that you would like to release? (Healthcare facility or provider)

Name:_____ Phone#:_____ Fax#: _____

Address: _____ City:_____ State:____ Zip:_____

Send the health information to: (Requestor) or PCG Office

_____
_____
_____
_____

-OR-

Physicians Care Group of West Georgia
100 Professional Park, Suite 204
Carrollton, Ga. 30117
PHONE 770-834-3351 - FAX 770-830-1518
Attention: _____

Information to be disclosed:
__Medical records dated: _____ to _____
___Last 3 Office Notes and Recent Labs, Diagnostic Reports, and Discharge Summary from Last hospital admission. Include records regarding HIV status: (initial) Yes____ No____

Reason For Release:
__Out of town move __Consult/second opinion __ New physician selected
__Personal __ Recommendation __Other: _____

Revocation:
I understand that this authorization will be in effect for 12 months, unless cancelled by me in writing. I understand that the information used or disclosed may be subject to re-disclosure by the receiving facility or provider and may no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Primary Care Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition their treatment of me whether or not I sign the authorization. **Fees for copies**: Federal and state laws permit a fee to be charged for copying of the patient records. You will be required to pre-pay for the copies. **Initial:** _____

Authorization:
I authorize the provider listed above to release the personal health information and send to the requestor.

Patient Signature: _____

Patients Printed Name:_____ Date: _____

If other than patient signing, please state relation to patient: _____