AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Full Legal Name: _____ Date of Birth: _____

Address: _____

Patient Phone Number(s) _____

I authorize and request: _____
Name of doctor or facility with old records

_____
Street address

_____
City State Zip

To release my records to: **INTERNAL MEDICINE SPECIALISTS OF ATLANTA, P.C.**

___Dr. J. David Spivey ___Dr. John E. Perry ___Dr. Robert B. Malamis ___Dr. Wesley A. Hoke ___Dr. John L. Elliott

___Sarah Rhodes, PA-C ___Hope Johnson, PA-C

1800 Howell Mill Road, NW
Suite 175
Atlanta, GA 30318
Phone: 404-607-1777
Fax: 404-607-1799

Date(s) of Service or Date Range Requested: _____

I understand that this authorization may be revoked by me at any time.
This revocation would not apply to information that has already been properly released.
This authorization will expire one year from the date it was signed.
I understand that information in my medical record may include information related to HIV/AIDS, confidential information, and may include psychological and mental health information. By signing below I also specifically authorize the release of this type of information.
I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of my records and it may no longer be protected by federal and state privacy regulations.
By signing below, I certify that I have the authority to sign this form and that all information I have provided is true, accurate and complete.

_____ _____
Signature of Patient or Legal Representative Printed (Legible) Name of Patient or Legal Representative

_____
Date Signed

If signed by Legal Representative, please provide the following information:

Relationship to Patient: _____