

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE OR TRANSFER
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

Instructions for Completion

1. You must state specifically what information you are requesting to be transferred or released.
Examples:
 - A. Medical summary, growth chart, complete immunization history
 - B. Complete medical record without restrictions
2. Complete the name and address of the party to whom the records are to be sent.
3. If you want to specify a time frame for the authorization, please enter a date in the field. If this section is left blank, the authorization will expire one year from the date of the form.
4. Complete the entire section of the form with signature, relationship to patient, patient name, DOB, date of signature and your name.

You may fax this information to Charlotte Richard, Medical Records Coordinator, at 770-772-6099, or you can mail to our office at

3400A Old Milton Pkwy
Suite 330
Alpharetta, GA 30005

There is a charge for production of medical records which is based on the size of the record. When sending this information, please include a contact number so that we can follow up with you.