1747 Langford Dr. Bldg 400-105, Watkinsville, GA 30677
(706) 769-1100 FAX (706) 310-9847

RECORDS RELEASE AUTHORIZATION

Patient Name:	Date of Birth:	SSN:

PURPOSE OF RELEASE

☐ **Legal or insurance** ☐ **Communication with specialist** ☐ **Transferring care**

Other (please specify) ______________________________

INFORMATION TO BE RELEASED:

☐ **All records** ☐ **Test Results** ☐ **Most recent visit**

Other (please specify) ______________________________

RELEASE TO:

☐**Patient** ☐ **Office or Facility**

Doctor/Facility:	Street address:	
City:	State:	ZIP:
Phone:	FAX:	

☐ **Free copy** *(one copy of the medical record is released to the patient or to another provider without charge)*

☐ **Fee assessed: $** ____________ Payment Method: __________

Search & Retrieval Fee	$25.88
Pages 1-20:	$0.97 per page
Pages 21-100:	$0.83 per page
Over 100 pages:	$0.66 per page
Postage Fees:	actual USPS postage fee (if applicable)

PATIENT'S RIGHTS AND SIGNATURE:

► *I understand I have the right to withdraw this consent at any time except where information has already been released.*

► *I understand this medcal record may contain information about drug abuse, alcoholism, alcohol abuse, sexcually transmitted diseases, abortion, or mental health treatment. Additionally, this medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment.*

► *I understand only one copy of my record will be released for free and all subsequent requests will be subject to the fee schedule listed above.*

______________________________ ______________

Signature of Patient (or parent/guardian if minor) Date