ATLANTA COLON AND RECTAL SURGERY, PA
RELEASE OF MEDICAL RECORD INFORMATION

Patient Name	Date of Birth	Date
Address	City State Zip	Daytime Phone

*I hereby authorize **Atlanta Colon and Rectal Surgery, PA** (hereinafter "Practice") to release information contained in the above-named patient's medical record, including records, if any containing psychiatric confidential information and records, if any for treatment of physical and/or mental illnesses, treatment of chemical dependency and/or alcohol abuse, or testing or treatment of any communicable or infectious disease, such as Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus, Venereal Disease (HIV), Acquired Immunodeficiency Syndrome Related Complex (ARC), Tuberculosis, or Hepatitis. I authorize such release to the person or organization listed below and under the conditions and for the purpose stated below:*

Name & address of person(s) / organization(s) to release records: (please print)

_____

_____

_____

Check the specific medical record information to be released: (Date of service:_____)

- ☐ office notes
- ☐ operative reports
- ☐ EKG report
- ☐ Other:
- ☐ discharge summary
- ☐ pathology reports
- ☐ X-ray reports
- ☐ history & physical
- ☐ laboratory report

_____

Reason for disclosure:

_____

☐ I authorize Atlanta Colon and Rectal Surgery, PA to send my records by facsimile transmission to

(_____) _____—_____

I understand this consent may be revoked by me at any time by written notice to Atlanta Colon and Rectal Surgery, PA unless the revocation is received after the records have been released. This authorization will expire sixty (60) days from the date signed unless otherwise specified below. I release the office and its employees, physicians and agents from all liability in complying with this request.

Signature of patient or authorized representative*	Date
Signature of Witness	Date

*If a minor, parent or guardian must sign. If legal guardian or estate representative signs, copy of court order must be attached. If patient is deceased, administrator for patient's estate must sign.

REORDER # 00-13311-30