

MCDANIEL & DURRETT, P.C.

105 Collier Rd Suite 1080

Atlanta, GA 30309

(404)352.2850

Fax# (404)352-0947

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
 Address: _____
 City/State/Zip Code: _____
 SS#: _____ Patient's phone #: () _____
Date of Request: _____ **Date Needed:** _____

OR

<input type="checkbox"/> I authorize MCDANIEL & DURRETT, PC to release information to: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	<input type="checkbox"/> I authorize MCDANIEL & DURRETT, PC to obtain information from: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)
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PURPOSE FOR THIS REQUEST: (Check one.) Healthcare Insurance coverage Personal Other Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)
 Immunization history Administered by the Center only. Include records submitted to the Center.
 All medical records related to a specific illness or injury.

Specify illness/injury _____ Date(s) of treatment _____

Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
 Specific information (Select one or more, as applicable)
 Procedure report History & physical Physical Therapy Laboratory test results
 X-ray reports Other _____
 (Please describe.)

Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

This request only.
 One year from the date of this authorization **OR** _____. (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
 This request **and** for medical records of any **future** treatment of the type described above until: _____
 Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient (if requester is not the patient) _____

Distribution: Original to medical record. Copy to requester, as required.