Atlanta Clinical Care, P.C.

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Diplomates, American Board of Internal Medicine and Infectious Diseases

MEDICAL RECORDS RELEASE

I hereby request and authorize: _____

_____

_____

_____

To release my medical records to: Atlanta Clinical Care, P.C.
5673 Peachtree Dunwoody Road, Suite 330
Atlanta, GA 30342
Ph# 404-459-0002 Fax# 404-459-0003

I understand the information will be used for continuation of care and my signature below indicates that I understand the records released include information regarding (please check all applicable) □drug and/or alcohol abuse, □ sexually transmitted diseases or □AIDS/HIV. This consent will expire on this specific date_____ or 365 days from the date of signature.

I understand that I may revoke this consent at any time, but that it will remain valid to the extent release based on this consent has already occurred.

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

Date: _____

Patient Name: _____

Patient Signature: _____

DOB: _____ SSN: _____

******* PLEASE FAX IMMEDIATELY TO ANY PHYSICIAN WHOSE RECORDS ARE PERTINENT TO YOUR VISIT WITH US*******