PERSONALIZED PHYSICIANS

I hereby authorize the Practice, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of: *(please print)*

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone No: _____
_____ SSN (last four digits):_____

RELEASE INFORMATION TO:

Personalized Physicians
709 Canton Road, NE
Suite 110
Marietta, GA 30060
Fax 770-792-7928

RELEASE INFORMATION FROM:

Name: _____
Address: _____
City/State/Zip: _____
Fax: _____

REASON FOR RELEASE:

__X__ Continuing medical treatment
_____ Other: _____

Type of Information: *(check all that apply)*

__X__ Entire Medical Record
_____ Progress Notes
_____ Diagnostic Testing Reports
_____ Imaging Reports
_____ Lab Results
_____ Consultations
_____ Therapy/Procedures Reports
_____ Other _____

Authorized Date: _____ **Expires:** _____

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal law and that is applicable to either drug/alcohol or mental health information or both. My signature authorizes release of all such information (as specified above and for the purposed mentioned above).

_____ _____
Patient's Signature or Legal Representative Relationship, if not the patient — Date

_____ _____
Signature of Witness — Date

Right to Revoke: I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must contact the following in writing: Personalized Physicians, 709 Canton Road, NE, Suite 110, Marietta, GA 30060