Peachtree Orthopaedic Surgery Center at Perimeter

5505 Peachtree Dunwoody Rd. Suite 200
Atlanta, GA 30342-1749

404-350-2450 phone **404-352-7420 fax**

PATIENT HIPAA RELEASE AUTHORIZATION

Patient Name:_____ DOB _____ Last 4 Digits of SSN: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email: _____

Reason for Disclosure: _____

Please release the following item(s) noted below from my medical record:

Service date(s): _____

__Progress Notes __Radiology/Ultrasound Reports __Complete Medical Record

__Lab Results __Operative Report __Other: _____

Receiving Party & Method of Delivery: ___ Mail (Complete info below if party is not patient)

___ Email (Please provide email above) ___ Fax ___Pick up in person

Name: _____

Address: _____

_____

Fax #:_____ **necessary if going to another physician/party

____ I understand that a fee for copying medical records may be incurred.

____I understand that this authorization will include any medical records including HIV records, alcohol abuse records and any other statutory protected disease unless otherwise stated so. This authorization and consent will expire 60 days following the date signed. I understand I may revoke this authorization at any time to the extent that action has previously taken in reliance hereof. **(Please check both to acknowledge)**

Date:_____ Signature:_____