Peachtree Orthopaedic Surgery Center at Piedmont

77 Collier Rd. Suite 2000
Atlanta, GA 30309

404-351-6393 phone **404-367-8259 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)

Patient/Authorized Signature _____ Date_____