South Atlanta Neurology & Spine Clinic
518 Eagles Landing Pkwy
Stockbridge GA, 30281
P- (770) 507-7359
F-(770) 507-8390

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ D.O.B: _____

Previous Name: _____ S.S.N: _____

I request and authorize:

_____

_____

_____

Phone Fax

to release health care information of the patient named above to:

_____

_____

_____

Phone Fax

This request and authorization applies to health care information to include:

- ☐ All records
- ☐ Office notes (previous 2 years)
- ☐ Radiology records (MRI's, CT's, X-rays, etc.)
- ☐ Billing records
- ☐ Labs
- ☐ Other: _____

Date From: _____ to _____ Expires: _____

☐Yes ☐No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐Yes ☐No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED UNLESS OTHERWISE STATED.