

Stewart Family Medicine

Authorization to Disclose Health Information

I hereby authorize _____ located at _____ (address)
_____ (phone) _____ (fax) to disclose or obtain information from the health records of:

Patient Name: _____
Address: _____
Date of Birth: _____ Phone: _____

Information to be disclosed (please check all that apply): This information is to be disclosed/released to:

- **Complete Medical Record** _____ Stewart Family Medicine
- _____ Physical and History _____ 4500 Hugh Howell Road, Suite 220
- _____ Labs _____ Tucker, GA 30084
- _____ Immunizations _____ (770) 469-0668(p) (770)469-0676
- _____ ER Reports _____
- Consultations _____
- Other _____

For the purpose of: (please check the appropriate box below):

Continued Medical Care Insurance Attorney Personal Other: _____

I understand that I have a right to revoke this authorization at any time. To do so, I must make such request in writing and present my written revocation to the Business Office. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. If I have questions about disclosures of my health records, I can contact the Privacy Officer.

Signed: _____ **Date:** _____
Patient

Patient Representative /Witness **Date:** _____
(please indicate relationship)