

Mailed Release Form

Hello,

The included document is a required release form for Atlanta Diabetes Associates to send medical records.

We can mail or FAX records to another doctor's office or company.

If you are requesting the records to be sent to you directly, you may also include an email address and we can send them through email. Be aware that they will be password protected and the password will be sent in a separate email.

The release can be sent back to us through mail to the address below:

Medical Records
Atlanta Diabetes Associates
1800 Howell Mill Rd NW
Suite 450
Atlanta, GA 30318

You may FAX the release back to us, our medical records FAX number is (678) 237-0991

You may email the scanned release to medrec@atlantadiabetes.com

You may call me with any questions.

Thank You,
Eric Robertson
Medical Records
Atlanta Diabetes Associates
(404) 419-9836



1800 Howell Mill Rd NW Ste 450
Atlanta, GA 30318
404-355-4393
FAX 678-237-0991

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ hereby request and authorize _____
_____ the name of the hospital, or physician name if requesting release from a physician's
office) to use or disclose medical records as described below.

Purpose of Use or Disclosure: _____ At the request of the individual
_____ Other: _____

Patient's Full Name: _____ SS# _____
Maiden /Other Name: _____ Telephone Number (Home) _____
Date of Birth: _____ Telephone Number (Work) _____
Current Address: _____

I further request and authorize use or disclosure of the medical records checked below to (please provide name, address, phone, and fax number):

This Authorization applies to the information checked below for the following date or dates of service: _____

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

- Entire Medical Record Financial Record Office Notes
- Laboratory Test Results Medication Record Treatment Plan
- EKG Report Other - specify _____
- Note- specify _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. You may pick up a revocation form from the Medical Records Department and return it there after you have completed and signed it. I further understand that the Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. Atlanta Diabetes Associates shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

I further understand that this Authorization is valid for a period of 90 days from today's date and will expire at that time unless another date is written here: _____

Patient's or Legal Representative Signature Please Print Name Today's Date

As a legal Representative, my relationship to the patient is _____. Any document outlining such authority should be attached. The patient is unable to sign because _____
There may be fees for provision of any or all request information