

North Atlanta Podiatry Group, P.C.
d/b/a
Foot & Ankle Centers of Northeast GA

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

RELEASE TO: _____

PATIENT NAME: _____

DATE OF BIRTH: _____ SS#: _____

YOU ARE HEREBY AUTHORIZED TO RELEASE COPIES OF:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> HIV/AIDS Report | <input type="checkbox"/> Hospital/ER Reports | <input type="checkbox"/> Drug Screen/Abuse | <input type="checkbox"/> EKG/Cardiac Reports |
| <input type="checkbox"/> Education Records | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Psych.History/Testing | <input type="checkbox"/> Rehab Reports |
| <input type="checkbox"/> Neurology Reports | | | |

For records being released from North Atlanta Podiatry Group, P.C.

I additionally understand that these records may be sent the most expedient way including by way of fax. Once released, North Atlanta Podiatry Group, P.C., its officers, directors, associates, and agents are hereby released from any legal liability that may arise from the release of information requested.

I understand this is subject to revocation at any time by the undersigned except to the extent that action has already been taken in reliance upon this consent. In any event, this consent will expire without revocation 90 days from the date signed.

This consent is executed on the _____ day of _____, 200_____

Signature of Patient _____

If consent is necessary from a person authorized to give the consent other than the patient (patient's representative)

Signature of patient's representative _____

Relationship to patient _____

This consent shall have a duration no longer than is reasonably necessary to effectuate the purpose for which it is given.