Endocrine Specialists of Georgia, LLC

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Authorization to Release Information To Family Member

Name of Patient: _____

Date of Birth: _____ **Phone Number:** _____

Social Security Number: _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record (s) of the above-named patient.

INFORMATION TO BE RELEASED OR ACCESSED:

☐ History & Physical ☐ Emergency Room Record ☐ Operative Reports
☐ Face Sheet ☐ Lab/Pathology Reports ☐ Radiology Reports ☐ Radiology Images
☐ ALL MEDICAL RECORDS

RELEASE TO: _____ Relation: _____

RELEASE TO: _____ Relation: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

_____
Printed Patient Name

_____
Patient Signature

_____
Date