Iron Mountain
Authorization for Release of Health Information

Name of Facility or Provider

Atlanta Medical Center Main/South Campus, 303 Parkway Dr., Atlanta, GA 30312

Patient Identification

Printed Name: ______________________________ Date of Brith__________ SSN__________
Address: ______________________________ Telephone____________________
______________________________ Medical Record Number____________________

Information To Be Released
From (date) ______________________________ To (date)______________________________

Please check type of information to be released:
__Compliance health record __Discharge summary __History and physical (H&P) __Consultant reports
__Progress reports __Radiology reports __EKG reports __Operative reports
__Lab reports __Emergency record __Abstract (discharge summary, consults, H&P, ER record diagnostic testing, pathology report, lab)

Other: ____

Purpose of Release __Medicare Care __Legal __Insurance __Personal

Who and Where to Send Information

Name: ____

Address: ______________________________ City: ______________ State: ________ Zip Code _______

Drug and Alcohol Abuse/Psychiatric, HIV/AIDS, Genetic Testing Records Release
I understand that my medical may contain information regarding the diagnosis and treatment of drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, genetic testing, and/or other sensitive information. I agree to its release. Check one:
__ Yes __ No If yes, please initial here _____
I understand that my medical may contain information regarding the diagnosis and treatment of HIV/AIDS testing and/or treatment. I agree to its release. Check one:
__ Yes __ No If yes, please initial here _____

Right to Revoke and Expiration
This authorization can be revoked in writing, at any time, except to the extent that information has already been released or disclosed. Unless otherwise specified, this authorization will expire automatically when the purpose for the release or disclosure has been achieved or one year from the date signed below, whichever comes first.

Re-disclosure
I understand that by signing this authorization that my information may be re-disclosed and may no longer be protected under HIPAA

Signature of Patient or Legal Representative
I understand that I do not have to sign this authorization, and my treatment (or payment for services will not be denied if I do not sign this form. I have read and fully understand the above statements as they apply to me and consent to the release of records for the purpose(s) state above.

Patient Signature: ______________________________ Date: ____________________

Parent or Legal Guardian Signature: ______________________________ Date: ____________________
A Legal Representative's signature will require attaching supporting legal documentation to include Death Certificate, Birth Certificate, Power of Attorney, Executor of Estate documentation to support your claim as legal representative.)