



AUTHORIZATION TO RELEASE YOUR PROTECTED HEALTH INFORMATION*

Patient Information:

 Patient's Name _____
 Date of Birth

 Street Address _____
 City _____ State _____ Zip Code

Recipient:

 Physician's Name _____
 Facility Name

 Phone Number _____
 Fax Number

 Street Address _____
 City _____ State _____ Zip Code

Sender:

Sugarloaf Medical P.C.
1300 Peachtree Industrial Blvd., Suite 4203
Suwanee, GA 30024
Phone: (770) 831-3018 | Fax: (770) 831-3669

Health Information to Be Released:

- All medical records Medical Summary (Medications, Vaccinations, etc.)
 Other _____ Other _____

Treatment Period:

- Information ranging from all dates on record
 Information within the following dates: _____ through _____.

Signature:

I am either the patient named above or the patient's legally authorized representative. By signing this form, I hereby authorize the sender to release the selected health information. I understand, acknowledge, and agree that:

- My medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information; I specifically agree to its release;
- Unless revoked, this authorization will expire on the following date or event, or one year from date of signature, unless otherwise specified;
- Once information is released to the above-named person or persons, my information may be subject to re-disclosure subject to specific restrictions on redisclosure as set forth below;
- I understand that the records may be provided to copy services for the sole purpose of copying said records.
- 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 unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed;
- I authorize the use and disclosure of the protected health information specified above;
- I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The authorization for Release of Information form does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibits information disclosed from records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient;
- I am fully responsible for the fees, if any, brought by this request;
- I may revoke this authorization in writing at any time, but that such revocation will not apply to information that has already been released.

I can mail this written revocation to:

Attention: Sugarloaf Medical P.C. Medical Records Department
1300 Peachtree Industrial Blvd., Suite 4203, Suwanee, Georgia 30024

Signature of Patient or Legally Authorized Representative *and relationship to patient*

Date

**Please note, most of our patient's medical records are available through the Patient Portal and Healow application.*