SUGARLOAF MEDICAL P.C.
Internal Medicine Primary Care

(P) 770·831·3018 (F) 770·831·3669
1300 Peachtree Industrial Boulevard,
Suite 4201, Suwanee, GA 30024

AUTHORIZATION TO *REQUEST* YOUR PROTECTED HEALTH INFORMATION

Patient Information:

_____ _____
Patient's Name Date of Birth

_____ _____ _____ _____
Street Address City State Zip Code

Sender:

_____ _____
Physician's Name Facility Name

Specialty:
☐ Primary Care Physician
☐ Specialist: _____

_____ _____
Phone Number Fax Number

_____ _____ _____ _____
Street Address City State Zip Code

Recipient: Sugarloaf Medical, P.C.

FOR SENDER'S USE:

Electronic Health Records (EHR) Transfer Methods:

- eClinicalWorks : Physician to Physician (P2P)
- Other Direct EHR : sugarloaf.medical@smimpc.eclinicaldirectplus.com

Mail a copy to:
Sugarloaf Medical, P.C.
1300 Peachtree Industrial Blvd., Suite 4203,
Suwanee, GA 30024

Fax a copy to: (770)831-3669

Health Information to Be Released (PLEASE DO NOT SEND ENTIRE RECORD)**:**

Please submit medical summary and relevant diagnostic reports from the last 5 years.

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