General Medical Records Release and
Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Phone: _____ Date of Birth: _____

Address: _____

_____

_____

Check all applicable information to be released:
□ All Records
□ Laboratory/pathology records □ X-ray / Radiology records □ Billing Records
□ Abstract/Summary □ Pharmacy/prescription records
□ Other (describe) _____

Note: I understand that the information in my health record may include information pertaining to treatment of drug or alcohol abuse, mental health, acquired immunodefiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information, cancer diagnosis or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE. DO NOT RELEASE (indicated with your initials) _____

The records are for services provided on the following date(s):
_____

Please send the records listed above to:

□ To □ From	□ To □ From
□Goga Vukotic, MD, PC	□ Name: _____
11050 Crabapple Rd.	Address: _____
Bld A – Ste 104-B	_____
Roswell, GA 30075	_____
Ph: 770-645-0017	Ph: _____
Fax: 770-645-0224	Fax: _____

The information may be used / disclosed for each of the following purposes:
□ At my request (only the patient can check this box) □ For employment purposes
□ For my health care □ Other: _____ □ For payment/insurance

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in six months or on this date listed:_____
I understand that after the custodian of records discloses my health information, it may not longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (patient's personal representative) Date

_____ _____
Printed name of patient/patient representative Relationship to patient

CONSENT FOR REALEASE OF INFORMATION