Atlanta Heart Associates, P.C.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date:_____ ❑ Office Visits ❑ Lab

Patient Name:_____ ❑ Cardiac Tests ❑ Op Notes

Date of Birth:_____ Patient Phone:_____ ❑ Discharge Summary

Social Security No: _____ ❑ All Records

Purpose or need for information:_____ (DOS) _____

IF MORE THAN 30 PAGES PLEASE MAIL

I hereby authorize that Atlanta Heart Associates, P.C.
❑ **RELEASE** the protected health information regarding the above named person **TO**:

OR

I hereby authorize that Atlanta Heart Associates, P.C.
❑ **OBTAIN** the protected health information regarding the above named person **FROM**:

Person/Institution:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Fax:_____

Please Check: ❑ Mail ❑ Pickup ❑ Fax

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION ON RE-DISCLOSURE: Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal regulation (24 CFR Part 2) prohibits recipients from making any further disclosure of this information except with specific written consent of the patient. HIV testing, ARC and/or AIDS related diagnosis is further prohibited from disclosure by State Regulations without the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for this purpose.

RE-DISCLOSURE: Notice is hereby given to the patient of legal representative signing this Authorization that **Atlanta Heart Associates, P.C.** cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

Signed:_____ Date Signed:_____
(Patient or Legal Guardian)

_____ Witness:_____
(Relationship to Patient)

Please allow **10-15 business days** to complete this request. We cannot release hospital records or records from other physicians. All records requested are subject to a processing fee; however, records can be faxed to another physician's office free of charge.

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TEL: 770/692-4000 Fax: 770/474-8510