AUTHORIZATION FOR RELEASE OF INFORMATION

Wellness Life Center
1180 5th St SE
Cairo, GA 39828
(phone) 229-397-5433 (fax) 229-397-0272

Patient Name: ______________________________ **Date of Birth** __________

Address: ______________________________

City/State/Zip: ____________________ **Telephone** ____________________

I authorize the release of medical information as indicated below:

FROM:

Practice Name: ____________________

Address: ____________________

TO:

Name: ____________________

Address: ____________________

☐ I would like to pick up my records: please call me at __________ ☐ I would like to records mailed (please indicate address above)

What to Release: Please choose the records you would like released:

☐ Outpatient notes
☐ X-Ray report(s)
☐ Pathology Report(s)
☐ Other Specify ____________________
☐ Laboratory reports
☐ X-ray Film(s)
☐ Immunization record
☐ All medical records

NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests	☐ Yes	☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	☐ Yes	☐ No/NA
The treatment and/or consultation for mental health or psychiatric disorders	☐ Yes	☐ No/NA

Purpose of the release: Please indicate the reason for this release

☐ For another doctor
☐ Use in a lawsuit
☐ Follow-up related to an injury
☐ Personal use
☐ To obtain disability
☐ Worker's care
☐ Armed forces requirement
☐ Other __________

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

☐ Please change the expiration date to last for __________ days.

I understand this Authorization can be revoked at any time according the [practice name's] privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by [Practice name] and may potentially be re-disclosed by the party who received these records. [Practice name], its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

______________________________ ____________________
Signature of the patient Date

______________________________ ____________________
Signature of legal representative and relationship to patient Date

______________________________ ____________________
Signature of witness Date

Form 10ARI