Primary Care Physicians of Atlanta, P.C.

Internal Medicine
5670 Peachtree Dunwoody Road, Suite 1200
Atlanta, GA 30342

(404) 255-9100 Fax (404) 257-7171
www.pcpatl.com

Lonnie Herzog, M.D., F.A.C.P.
David A. Smith, M.D.
Samuel F. Adams, M.D.
Sandra K. Banks, M.D.
Russell C. Maxa, M.D.
Scott J. Small, M. D.
Thomas L. Weeks, III, M.D
Ngoc Diem Anke Doan, M.D
Cesar M. Cestero, M.D.
Alexander M. Herzog, M.D.
Max E. Green, M.D.

Consent for Release of Protected Health Information (PHI)

I, _____, at the request of the recipient named below and/or myself, request that you release my PHI to:

_____

_____

_____

_____

I have marked the boxes below to indicate what PHI is to be released:

□ All clinical chart records/reports (possibly including insurance information) including the following: (strike through any of the following you don't want released)

- Information regarding genetic testing
- Information regarding the diagnosis, testing, and/or treatment of HIV and other venereal diseases
- Information regarding the diagnosis, testing, and/or treatment of mental/psychiatric illness from a mental health professional
- Information regarding the diagnosis, testing, and/or treatment of drug, alcohol or other substance abuse

□ X-rays (I understand an additional fee may be charged for making copies of the x-ray films).

□ Billing/financial records (not normally part of the clinical chart records/reports)

Dates of records to include: ☐ All dates
☐ Limited to these dates:_____

This consent expires after the aforementioned information has been released, but does allow the above recipient six months to request additional information that may have been inadvertently omitted, needs clarification due to processing problems (e.g. illegibility), or needs to be resent.

I understand that I may revoke this request at any time, but any information already released in reliance of this form, prior to my revocation, will not be affected. Once released, I understand that this information might be subject to redisclosure by the recipient and might no longer be protected.

I understand that any treatment I need is not dependent upon my signing this form, unless the treatment is specifically for research purposes or intended for use by a third party (e.g. drug testing for employment).

Date:_____

Patient's Signature_____ SSN:_____

OR

Legal Representative's Signature_____ SSN:_____

Relationship:_____ (Printed name):_____