MEDICAL WELLNES CENTER OF GEORGIA, LLC

AUTHORIZATION and CONSENT

I understand that my medical records may be used to carry out treatment, payment, or health care operations. I authorize Medical Wellness Center of Georgia to release medical or other information about this care to other referring physicians, my personal physician, discharge planner, Medicare, Medicaid, and all other health insurance companies to complete patient claims as well as appropriate government agencies of the U.S. as may be required by Federal Law.

I hereby voluntarily consent to care, treatment, testing, and all other services performed by healthcare providers at Medical Wellness Center of Georgia. I understand that I may revoke this consent at any time via written, dated, and signed communication letter provided to this office.

Due to HIPAA regulations, we are not permitted to release information regarding your medical history to people that are not authorized by you to do so. If you would like any family member(s), etc. to call and/or receive information about you including your medical condition, diagnosis, treatment plan(s) and/or payment plan(s), please list them below:

Name: _____ Relationship: _____ Phone: ( ) _____
Address: _____ Check if in case of emergency only: □

Name: _____ Relationship: _____ Phone: ( ) _____
Address: _____ Check if in case of emergency only: □

I request the following restrictions be placed on the use or disclosure of my health information:
_____

Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues to improve safety and quality. This data can indicate compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy. The history would include medications prescribed by your health care provider at Medical Wellness Center of Georgia, as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, substance (drug and alcohol) abuse, genetic and other diseases. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Please indicate below if consent for Medical Wellness Center of Georgia, LLC to obtain your medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes is granted.

□ I hereby provide informed consent to obtain my medication history.
□ I decline this option. I do not give permission for access to the above information.

PATIENT NAME: _____ **DOB:** _____

_____ _____ _____
Signature of Patient/Legal Representative ***Relation if other than patient*** ***Date***