MEDICAL WELLNESS CENTER OF GEORGIA, LLC

AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name: _____ **Dob:** _____ **Today's Date:** _____

Address: _____

Guardian or Authorized Party (if applicable): _____ DOB: _____

I authorize the release and disclosure of my health information as described below:

- **Records relating to treatment dates from _____ to _____**
- **ALL Records at the facility or by this provider listed below: (Circle One) YES / NO**
- **Other (Please specify) _____**

I understand that I have the right to revoke this authorization in writing at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards. _____ ***(Initials of patient or guardian)***

Information to be Released **From:** _____ **Ph:** _____
Name of facility or provider releasing records

☐ **SEND RECORDS TO:** **MEDICAL WELLNESS CENTER OF GEORGIA, LLC** **FAX:** _____
Address: _____ ***Phone:*** _____
_____

☐ **SEND RECORDS TO:** _____ **VIA:** □ **FAX** □ **MAIL** □ **PICK UP**
Name of facility or provider receiving records

FAX NUMBER: _____ **OR MAILING ADDRESS:** _____
_____

Email: _____ _____

I understand that the provider above may not condition treatment on my signing this authorization and that I have a right to refuse to sign.

_____ _____ _____ _____
Signature of Patient or Guardian ***Date*** *Signature of Witness* *Date*

** If authorization is signed by a personal representative, the representative's authority is based on _____
(e.g., state law, court order, POA, etc.)

FEE SCHEDULE: State and Federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records..
No fee shall be charged for reproducing and forwarding records directly to other physicians.

Notice to Patients: By choosing to utilize Email communication, you are acknowledging that email may not be completely secure. Selection of Email option and signature are documentation of patient and/or guardian acknowledgment of these risk and hereby grant permission to utilize email.

A fax copy, or photocopy of this consent shall be as valid as the original.