Southern Crescent Family Practice LLC
455 Forest Parkway
Forest Park, Ga 30297
(T) 678-705-0100
(F) 678-235-1800

AUTHORIZATION FOR RELEASE OF INFORMATION OR MEDICAL RECORDS

Patient's Name: _____ DOB: _____ SSN: _____

Patient's Address: _____ City, State and Zip: _____

RELEASE OF INFORMATION FROM: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____ Contact Person: _____

☑ I authorize _____ to release information contained in my medical records including records protected under Code 42 of Federal Regulations, Part 2 (if any), information related to HIV infection or AIDS, (if any), psychological services records, (if any), and Social Services records, (if any), including communications made by me to a social worker, psychologist or other practitioner, to the individuals or organizations listed below, under the conditions listed below:

Name of Person(s) or Organization to whom disclosure is to be made:
Southern Crescent Family Practice, LLC or Faith Andrews, MD
455 Forest Parkway,
Forest Park, GA 30297
Tel: 678-705-0100 / Fax: 678-235-1800

INFORMATION TO BE RELEASED:

Specific type of information to be disclosed:

☐ Most Recent Office Notes/ Lab Results ☐ Medication List ☐ Last Physical ☐ All Recent lab Reports
☐ Shot Records ☐ PAP/ Mammograms ☐ All Consult Notes ☐ All Medical Records

☐ Other (specify): _____

Information to be: ☐ Mailed ☐ Faxed ☐ Picked Up (If picking up, by whom)

Name: _____ Include letter of authorization if someone other than patient.

PURPOSE AND NEED FOR DISCLOSURE:

☐ Continuation of Care ☐ Employer Request ☐ Consultation ☐ Insurance Claim

REVOCATION CLAUSE:

This authorization is subject to written revocation at any time except to the extent Southern Crescent Family Practice, LLC has already taken action in reliance on the authorization. If not previously revoked, this authorization will terminate sex (6) months from the date of signature.

SIGNATURE: _____ DATE: _____
(Patient, Parent or Legal Representative)

Relationship: _____ Witness: _____ Date: _____

Submit