PLEASE COMPLETE TO HAVE YOUR RECORDS COPIED

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Note: Form MUST be completed before signature is obtained)

PATIENT NAME_____
LAST FIRST MI MAIDEN

DATE OF BIRTH____/____/____ SS#___-____-____ MEDICAL RECORD #_____

_____
ADDRESS CITY STATE ZIP

DAY PHONE_____ EVENING PHONE_____

☒ I authorize Douglas County Family Practice, P.C. to disclose my protected health information as indicated below to:

Arbor Place Family Medicine, P.C. (Dr. Thomas Varughese)

Name of entity to receive this information

6095 Professional Parkway, Building B, Suite 200 Douglasville Georgia 30134
ADDRESS CITY STATE ZIP

_____
PHONE NUMBER FAX NUMBER

INFORMATION TO BE RELEASED	**PURPOSE OF DISCLOSURE**
• Medication List, Problem List, Immunization Form and Diabetic Flowsheet • Office notes for the last one year • Most recent EKG, Echo, Exercise/Nuclear Stress Test • X-ray reports for the last one year • Lab reports for the last one year • Most recent spirogram/PFT • Any drug/alcohol, AIDS/HIV, STD, mental health information • Other_____	☒ Continuing Care

I understand that this authorization will expire: 6 months from date signed
Expiration Date or Defined Event

I understand that my health care and the payment for my health care will not be affected if I do not sign this form and that I may refuse to sign it. **INITIALS**_____

I understand that I may revoke this authorization at any time by notifying Douglas County Family Practice, P.C. in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization. **INITIALS**_____

I understand that a charge may be incurred to copy these records. **INITIALS**_____

_____ _____
Signature of Patient or Legal Guardian Date