Apollo Family Medicine
Dr. Asmita Joshi, M.D.
3990 Old Milton Pkwy, Ste. 200
Alpharetta, GA 30005
TEL#: (470) 875-1560
FAX#: (470) 781-2710

Authorization to Release Medical Records

Patient Name		SSN	
Date of Birth		Dates of Service	

To: ____
Name of Healthcare Provider/Physician/Facility

____
Street Address

____
City, State, Zip Code

I, the undersigned, authorize and request the release of or request access to the information specified below from the medical records of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical		Specialists Consultation Reports		Emergency Room Record	
Surgery Reports		Hospital Discharge Summary		Medication List	
Lab/Path Reports		X-Ray/Radiology Reports		Other:	

PLEASE RELEASE THE ABOVE INFORMATION TO:
Apollo Family Medicine
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Alpharetta, GA 30005
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CONTINUED

I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

____ _______________
Signature of Patient or Legally Authorized Representative Date

____
Name of Patient or Legally Authorized Representative

____ _______________
Signature of Witness Date