Habersham Medical Group
Internal Medicine & Geriatrics

**Authorization to Release Protected Health Information**

I, _____ _____
(Patient's Full Name) (Date of Birth)

Hereby request and authorize: _____

to release the following information for continuation of care to: **Internal Medicine and Geriatrics**
**638 Historic Hwy 441 N. Suite B,**
**Demorest GA 30535**
**P: 706.839.4092 F: 706.839.1970**

☐ All Records ☐ History & Physical ☐ Clinic Notes ☐ Abstract/Summary
☐ Discharge Summary ☐ Surgical Reports ☐ Pathology Reports ☐ Emergency Notes
☐ Radiology ☐ Other: _____

**Delivery Method Preferred**: ☐ Fax ☐ Mail ☐ Other: _____

**I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information**. _____ (Please Initial)

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I understand that: I may refuse to sign this authorization and that is it strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal Privacy Regulations and may be disclosed.

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**Signature: _____ Date: _____**