



**Authorization to
Release Protected Health Information**

Office of Dr. William McLean and Dr. James Dallis

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

Hereby request and authorize: _____

to release the following information for continuation of care to:

ORTHOPAEDICS OF NORTH GEORGIA

274 Adams Drive Demorest, GA 30535

P: 706-839-4096 F: 706-839-4097

Please Circle All That Apply:

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)

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 365 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.

Signature: _____ Date: _____