GEORGIA PAIN ASSOCIATES

Locations
2000 Village Professional Drive, Suite 200, Canton, GA 30114
2060 Northlake Parkway, Tucker, GA 30084
5745 Old Winder Hwy, Suite C Braselton, GA 30517

SEND INFORMATION TO:
2000 VILLAGE PROFESSIONAL DRIVE, SUITE 200, CANTON, GA 30114
PHONE 678-245-6246 FAX 678-265-4299
EMAIL: newpatient@georgiapainassociates.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Only complete areas with ★

★ **PATIENT IDENTIFICATION:**	Name: _____ Date of Birth: _____ S.S.#(last four digits only): _____ Maiden/Other names known by:_____ Patient Phone:_____
RELEASE FROM:	Name: _____ Address:_____ Phone:_____ Fax: _____
RECORDS REQUESTED:	❑ Medical Records (last 3 office visits) ❑ Lab Results ❑ Billing Statement ❑ Imaging Reports (X-Ray, CT, MRI) ❑ Demographics ❑ Other:_____ Dates to be included: From: _____ To: _____
PURPOSE OF RELEASE:	❑ Medical Care ❑ Insurance ❑ At the request of patient ❑ Other, Please Explain:_____

I hereby authorize **Georgia Pain Associates** to use and/or disclose the protected health information described above. I hereby authorize and understand that this release will include my complete health record **(including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). Georgia Pain Associates** may also share any and all information in my file with any and all local, state and/or federal authorities in the prevention of any illegal drug diversion. I understand by approving the release of information in the form of a fax, that confidentiality cannot be assured and I accept the risk that confidentiality may be breached when faxing information. I hereby release **Georgia Pain Associates** and its employees from any and all liability that may arise from this release of information.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization has no expiration date.

★ Signature of Patient/Legal Representative: _____Date: _____

Printed Name (if not same as patient):_____

Relationship to Patient: _____

PLEASE NOTE:

When your Medical information is released pursuant to a valid authorization the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rules.