# Authorization for Release/Disclosure of Medical Information

**Please REQUEST Medical Information FROM:**

Name of Medical Office/Hospital: _____

Mailing Address: _____

CITY STATE ZIP CODE

Phone Number: _____ Fax Number: _____

**Please SEND Medical Information TO:**

Name of Medical Office/Hospital: **Aylo Health - Imaging at Stockbridge**

Mailing Address: **1100 Hospital Drive** **Stockbridge** **GA** **30281**

CITY STATE ZIP CODE

Phone Number: **678-432-6161** Fax Number: **(678) 432-3677**

**I hearby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.**

Full Name of Patient: _____

Date of Birth: _____ Phone Number: _____

Address: _____

CITY STATE ZIP CODE

**Duration** This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature if no date entered.

DATE

**Revocation** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

**Redisclosure** I understand that the requester may not lawfully further use or disclose is specifically required or permitted by law.

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**Specify Records to be Released/Disclosed:**
*(Check which information is to be released/disclosed; If not specified 2 years will be provided by default)*

- ☐ **General Medical Information** (from _____ to _____)
- ☐ **Information Regarding Specific Injury or Treatment** (from _____ to _____)
- ☐ **X-Ray** (Check one or both): ☐ **Films** ☐ **Reports**
- ☐ **Laboratory Results**
- ☐ **Mental Health** (from _____ to _____) _____ PATIENT SIGNATURE _____ DATE
- ☐ **Alcohol/Drug** (from _____ to _____) _____ PATIENT SIGNATURE _____ DATE
- ☐ **HIV Test Results** (from _____ to _____) _____ PATIENT SIGNATURE _____ DATE
- ☐ **Other** (specify): _____

**I request that the health information released/disclosed pursuant to this authorization be used for the following purposes only: Review of Medical Records**

A copy of this authorization is as valid as an original. I have this right to receive a copy of this authorization.
*By signing this release form, you are giving Medical Office/Hospital authorization to send records by email.*

_____ SIGNATURE OF PATIENT OR REPRESENTATIVE _____ DATE

_____ RELATIONSHIP TO PATIENT