AUTHORIZATION FOR RELEASE OF INFORMATION TO THE EMORY CLINIC, INC.

To be completed if records are being requested from another facility to be sent to The Emory Clinic, Inc.

Patient Name: ______________________ Social Security Number: ______________

Previous Name, if applicable: ______________________

Address: ______________________ City: ______________ State: __________

Date of Birth: ____________ Home Phone: ______________ Work Phone: ______________

1. **FACILITY SENDING HEALTH INFORMATION:**
   Name: ______________________
   Address: ______________________
   City: ______________ State: __________ Zip Code: __________
   Fax Number: ______________________
   Telephone Number: ______________________

I hereby authorize the facility named above to release information contained in the above-named patient's medical records, including records, if any, for treatment of physical and/or mental illness, treatment of chemical dependency and/or alcohol abuse, or testing or treatment of any communicable or infectious disease, such as Acquired Immunodeficiency Syndrome (AIDS); Human Immunodeficiency Virus (HIV); Acquired Immunodeficiency Syndrome Related Complex (ARC); Venereal Disease; Tuberculosis; or Hepatitis to:

Emory Special Diagnostic Services
1365 Clifton Rd, NE, Suite A1208, Atlanta, GA 30322
FAX: (404) 778-0980

2. **DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**

☐ Complete medical record (*Please specify dates of service*): ______________________
OR
☐ Partial medical record (*Please specify records below)*

Information	Dates	Information	Dates
☐ History & physical	______	☐ Office notes	______
☐ Consultations	______	☐ Operative reports	______
☐ Discharge summary	______	☐ Pathology reports	______
☐ Lab results	______	☐ EKG reports	______
☐ X-rays	______		

☐ Other (*Please specify dates of service*): ______________________

3. **PURPOSE/NEED FOR DISCLOSURE:** ______________________

4. I authorize the facility named above to send the medical information requested by fax. (404) 778-0980

This authorization will expire sixty (60) days from the date signed unless otherwise specified.

______________________ Witness

______________________ Signature of patient, parent of minor, legal guardian or estate representative

______________________ Date

______________________ Date

COMPLETE AND SEND TO HEALTH CARE FACILITY OR YOUR PHYSICIAN'S OFFICE