Patient Authorization for Release of Medical Information

This form allows FAR-GA to send records on your behalf

Foot and Ankle Reconstruction Center of Georgia

1025 East Freeway Drive SE, Conyers, GA 30094
Phone: 770-929-3338 Fax: 770-760-7942

Patient Name _____ Date of Birth _____ Last 4 digits SS# _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Email _____

I hereby authorize Foot and Ankle Reconstruction Center of Georgia, its medical staff, employees, and their representative to release my protected health information in the manner listed blow and to the following:

Send by: (choose ONE:) Mail Fax Secure Email

Send to:

Name _____

Address _____ City _____ State _____ Zip _____

Phone # _____Fax # _____ Email _____

Please send:

- ☐ Progress Notes
- ☐ Diagnostic Test
- ☐ Operative Notes
- ☐ X-rays
- ☐ MRI/CT Results
- ☐ Laboratory Test Results
- ☐ Other: _____

** Depending on your request, it can take 2-3 weeks to receive records, though most requests are fulfilled sooner **

This authorization will not expire except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written request to Foot and Ankle Reconstruction Center of Georgia. I understand that the revocation will not apply to information that has already been release in response to this authorization. I understand that once the information is discolored, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations. I understand FAR-GA will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise authorized by law. A copy of this authorization may be utilized with the same effectiveness as the original. I am entitled to receive a copy of this authorization.

_____ _____

Signature of Patient/Guardian/Power of Attorney/Healthcare Surrogate Date

_____ _____

Printed Name Relationship to Patient if Applicable

FAR GA
Foot and Ankle Reconstruction Center of Georgia