

Greater Athens Physicians, Inc.

H. Philip Morris, MD

774 Athens Rd

Lexington, GA 30648

phone: 706-743-8183 fax 706-743-3233

Authorization Release of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

I authorize GAP, Inc to RELEASE information to:

Name: _____

Address: _____

Phone: _____

Fax: _____

I authorize GAP, Inc to OBTAIN information from:

Name: _____

Address: _____

Phone: _____

Fax: _____

I hereby authorize the above Physician/hospital/facility to release information including, if any, psychiatric or psychological information, infections or contagious disease information (including HIV/AIDS) and or information about drug or alcohol abuse or treatment of the same from the health records.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Reason for Release/Obtaining of Information: _____

Patient/Legal Representative Signature: _____

Office Staff Signature: _____

Date: _____

Date request will expire: _____