Greater Athens Physicians, Inc.
H. Philip Morris, Jr., M.D.
855 Gaines School Road, Ste G
Athens, GA 30605
Phone: (706) 543-6443 Fax: (706) 543-8202

Authorization Release of Medical Information

Patients name:_____ Date of Birth_____
Address:_____
City/State/Zip:_____
Date of Request:_____

OR

☐ I authorize H. Philip Morris, Jr. M.D. to release information to :	☐ I authorize H. Philip Morris, Jr. M.D. to obtain information from :
Name of Provider or Facility	Name of Provider or Facility
Address	Address
Phone # / Fax #	Phone # / Fax #

CONSENT FOR RELEASE OF MEDICAL INFORMATION INCLUDING, IF ANY, HIV, AIDS, PSYCHIATRIC, AND SUBSTANCE ABUSE

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.

To release my:

- ☐ Complete Medical Record for last three years of office notes, all lab reports, all radiology studies and any hospitalizations.
- ☐ Other as follows:_____
  _____

Patient / Legal Representative Signature:_____
Office Staff / Witness Signature:_____
Date:_____
Date request will expire:_____