

Greater Athens Physicians, Inc.

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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: _____