Greater Athens Physicians, Inc.
H. Philip Morris, MD
1450B Barnett Shoals Rd
Athens, GA 30606
phone: 706-543-6443 fax 706-543-8202

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 eligibilty 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:_____