Urology of Greater Atlanta, LLC
290 Country Club Drive Suite 100
Stockbridge, GA 30281
Phone (770) 474-5281 Fax (770) 389-8674

Patient's Name _____

Patient's Address _____

Date of Birth _____ **Phone**_____

I do hereby authorize Urology of Greater Atlanta, LLC to:

☐ **Release** of all medical records pertaining to me:
(*WITH THE EXCEPTION OF ALCOHOL & DRUG ABUSE AND OR HIV/AIDS RELATED INFORMATION)*

☐ **Obtain** all medical records pertaining to me from:
Name: _____
Address _____
Phone: _____
Fax: _____

For the purpose of:

☐ Moving away ☐ Personal copy ☐ Transfer to new physician

☐ Second opinion ☐ Another treating physician ☐ _____

The records should be:

_____ Sent to me at my home address on file

_____ Sent to Urology of Greater Atlanta, LLC

_____ Sent to the following person (s)

Name: _____

Address : _____

City State Zip: _____

Phone: _____

Facsimile: _____

This Authorization shall remain in effect until revoked by me in writing. If not revoked by me in writing, the Authorization shall remain in effect for one (1) year from the date of the signature below. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this Authorization Form. I understand that if I wish to revoke this Authorization, I must do so in writing and present my written revocation to Urology of Greater Atlanta, LLC. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.

Patient Name **Date of Birth** **Social Security Number**

Signature **Date** **Relationship to Patient**

When a representative of the patient signs this form, the representative must provide a description of such representative's authority to act for the patient: _____.