EVANS MEDICAL GROUP

Authorization for Release of Medical Records

(To obtain records from another Professional Medical Facility.)

I, _____, authorize the following protected health information
Person Authorizing Release

Released from the medical record of:

Patient Name: _____

Date of Birth: _____

Address: _____

_____

Phone# _____

Social Security #_____ _____ _____

Medical Records Released from:

Name of Physician:_____

Address:_____

City, State, Zip_____

Phone_____Fax_____

Medical Records Released to:
Evans Medical Group
465 N Belair Road, Ste 1B
Evans Georgia 30809
706 868-3100 706 228-3125 fax

_____Robert Lamberts, MD _____Michael Ikeler, MD
_____Christopher Apostol, DO _____Barry Jordan, MD
_____Lauren Wieme, PA-C _____Delores Schwartz, PA-C

Reason for Release of information: Primary Care Physician, coordination of care

Please send the following: **( ) Most Recent or Last 12 months**
( ) Office visit (s) ( ) Labs ( ) Radiology Studies
( ) Chart Summary ( ) Immunization Record ( ) Other_____

I understand that this authorization is valid for six months unless I notify Evans Medical Group otherwise. I may revoke this authorization in writing at any time except to the extent that Evans Medical Group has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Evans Medical Group, Medical Records Department to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"): treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. *I understand that I may be billed per the fee schedule for medical records with the exception of records directly released from Evans Medical Group to another Professional Medical Facility.* This information will be requested in a prompt manner according to the standards of Evans medical Group provided all information has been supplied to Evans Medical Group correctly.

_____

SIGNATURE OF PATIENT Relationship DATE
PARENT / LEGAL REPRESENTATIVE

If completing on behalf of another adult, a signature is required from that individual. If you have Power of Attorney on behalf of another individual, please provide us with a copy of the legal document. POA copy attached._____

EMG Staff Only Date Released:_____ Release by:_____

Notes:_____02/10