ATLANTA HEADACHE SPECIALISTS

Release of Medical Records

Please send this form to the provider you are requesting send records to our office.

Patient Name: ____

Date of Birth: ____________________________ Phone: ____________________________________

Address: ____

City: _________________________________ State: ______________________ Zip: ______________

I request that: ____
Physician

____
Practice

____
Address

__________________________________ __________________________________
Phone *Fax*

Release the following medical information relating to the patient listed above:

_____ Complete health records
_____ Physical exam
_____ Immunization record
_____ Other (please specify): EEG, EKG, and Quotient results.
_____ Lab results/X-ray reports
_____ Consultation reports

Please send the records to:

Atlanta Headache Specialists & PANDA Neurology
5887 Glenridge Drive, Suite 140
Atlanta, Georgia 30328
FAX: 678-973-0578

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____ .

If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

Jennifer Taylor, the Privacy Officer at PANDA Neurology & Atlanta Headache Specialists

__________________________________ __________________________________

Signature of patient or legal representative

Signature of witness

Date: ______________________________

Date: ______________________________

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.