HIPPA AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

COMPASS PRIMARY CARE
1720 Phoenix BLVD STE 700
College Park, GA 30349
Phone (470) 369-7800 Fax (470) 369-7801

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

Patient Information:

Patient Name: _____ Date of Birth: _____ Last 4 of SSN: _____

Compass Primary Care has my permission 0 to receive from OR 0 to release to the requested records:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____Fax Number_____

For the purpose of: ____Further Medical Care ____Insurance Billing ____ Legal Reasons ____ Self

____ Other (Please Specify) _____

(Check all applicable)

____ Last 3 notes ____ ER/ discharge Summary ____ Laboratory/pathology records ____Pharmacy/prescription records

____X-ray/radiology records ____ Clinic notes/ chart summary ____ Billing Records

____ Other (describe specifically)_____ For the following dates of service:_____

Unless you state otherwise, this authorization **includes** the release of all medical records and information, except as otherwise noted below. This authorization includes any records regarding drug, alcohol, or psychological or psychiatric conditions, including psychotherapy notes to the person(s) listed above.
Unless you state otherwise by marking one or both boxes below, this authorization includes the release and disclosure of STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
Definition: Sexually Transmitted Disease (STD) includes herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, chanchroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

____ I object to the release of STD/HIV/AIDS confidential information.
____ I object to the release of any psychological or psychiatric conditions, including psychotherapy notes under Georgia law.
____ I object to the release of any confidential information regarding drug and or alcohol treatment or notes.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.