AIM
ALBANY INTERNAL MEDICINE

PRIVIA
MEDICAL GROUP
GEORGIA

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize _____
Patient Name Hospital / Medical Group / Physician Name

release my Medical Records to _____.

Please release the following information for Date of Service: _____.

_____ Discharge Summary	_____ Consult Report	_____ ER Reports
_____ History & Physical	_____ Lab Report	_____ Eye Exam Report
_____ Operative Report	_____ Radiology Report	_____ Mammography Report

_____ Other Reports: _____

Social Security Number: _____ Date of Birth: _____

_____ Please FAX the records to: _____

_____ Please Mail the requested medical records to the address at the bottom of this page.

I understand this authorization includes release of medical records, which may include information regarding Human Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, Venereal disease, and or any other statutory protected disease. This authorization and consent will expire 90 days following the date signed. I understand that I may revoke this authorization and consent in writing at any time except to the extent that action has been taken in reliance thereon. If I sign for my minor child, I consent that I am the custodial guardian. Furthermore, I understand that these records are for the purpose of continuity of care and cannot be further released or disclosed.

_____ Date: _____
Patient/Guardian Signature

_____
Relationship to Patient

_____ Date: _____
AIM - Witness Signature

2402 Osler Court, Albany, Georgia 31707
(229) 438-3300 FAX: (229) 438-3384