ALBANY INTERNAL MEDICINE

PRIVIA MEDICAL GROUP GEORGIA

AIM MR# _____ **AIM Provider_____**

AUTHORIZATION FOR RELEASE OF INFORMATION

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

to release my Medical Records to ALBANY INTERNAL MEDICINE.

I hereby authorize disclosure of the following information:

_____ My entire medical record _____ Imaging Report _____ Lab Report
_____ Immunization Records Only
_____ Entire medical record for service dates _____ to _____
_____ Specific Information Only:_____
_____

Patient Date of Birth: _____ Patient Phone Number:_____

_____ Please FAX the records to ATHENA FAX (844) 971-5900 direct.

_____ 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 one year 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

2402 Osler Court, Albany, Georgia 31707
Office Line (229) 438-3300 General Correspondence only FAX: (844) 971-5900