Grayson Family Care, LLC
your health is our priority

GRAYSON FAMILY CARE AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, voluntarily authorize:

Facility Name_____
(PCP/Clinic/Specialty Physician/Hospital/Emergency Room/Urgent care clinic)

Address_____

City _____State _____ Zip Code_____

Phone:_____Fax:_____

To release my confidential personal health information as described below **To:**

Grayson Family Care, LLC
1700 Tree Lane, Suite 160
Snellville, GA 30078
FAX: 1-888-815-1113

INFORMATION TO BE DISCLOSED ABOUT

Patient name_____ Date of Birth_____

Phone _____

INFORMATION TO BE DISCLOSED

___ Medical Office Records	**___ER/Hospital Records**	**___ Protected Health Records**
___ ENTIRE CHART ___ OFFICE NOTES ___ CONSULT NOTES ___ PROCEDURE NOTES ___ LAB TEST RESULTS ___ IMAGING RESULTS ___ IMMUNIZATION ___ MEDICAL SUMMARY	___ RECENTADMISSION H & P ___ PROGRESS NOTES ___ RECENT D/C SUMMARY ___ CONSULT NOTES ___ PROCEDURE NOTES ___ LAB TEST RESULTS ___ IMAGING RESULTS	**DIAGNOSIS AND TREATMENT RELATED TO** ___ HIV/ AIDS ___ ALCOHOL/DRUG USE ___ MENTAL HEALTH ___ PSYCHIATRIC EVAL ___ AUTHORIZE ____ INITIAL ___ DO NOT DISCLOSE_____ INITIAL

Other Specific Record /Reports - ____ Mammogram ____ Pap test ____EGD/Colonoscopy with biopsy____
Echocardiogram ____Stress test _____ Holter test ____ CT SCAN/ MRI ____ EMG ____ EEG____ other _____

I understand that unless otherwise indicated above, my authorization also includes consent for protected health records.

I also understand this authorization gives permission to Grayson Family Care to request and receive Protected Health Information from previous providers, clinics & hospitals in order to provide continuous, and coordinated care.

This authorization is valid for one year from the date signed and can be revoked anytime by providing a written notice to Grayson Family Care. A photocopy or scan of this authorization shall be considered a valid authorization.

Signed _____ Date: _____

Print Patient Name_____

Name of Legal Representative/ Parent/ Guardian _____