Gainesville Heart and Vascular Group
Authorization for Release of Confidential Medical Information

Patient Name: _____ Date of Birth: _____

Patient S.S. #: _____-_____-_____ Patient Phone #: _____

Treatment dates to be released:_____

Type of Visit: ☐ Inpatient ☐ Outpatient ☐ ER ☐ Outpatient Test ☐ Therapy

This information is to be released:

☐ To ☐ From

Health Care Provider: Gainesville Heart and Vascular Group
Address: 705 Jesse Jewell Parkway #200
Gainesville, GA. 30501
Phone: 770-534-9014
Fax: 770-534-9012

Purpose of the Disclosure (Check One):
☐ Insurance Billing ☐ Legal ☐ Continuing Care ☐ Other (Specify):_____

The information disclosed may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules.

I hereby authorize Gainesville Heart and Vascular Group to disclose/release medical records and/or other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable for Legal, Insurance and/or personal use

I hereby release Gainesville Heart and Vascular Group from any liability, which may result from this disclosure of confidential information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intentions.

Unless withdrawn, this consent will expire 12 months from the date signed.

☐ This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.

☐ I authorize that this information may be faxed to the requesting Health Care Provider.

Patient Signature: _____ Date: _____

Authority to sign on behalf of the patient is authorized by: _____

Witnessed by: _____ Date: _____