Dear Dr._____Facility Address or Fax #: _____

By signing this authorization, I authorize the use and/or disclosure of certain protected health information (PHI) about me to or for the parties listed below.

__ **I hereby request that my medical records be released to ATL Colorectal Surgery, PC**
__ Please FAX my records to ATL Colorectal Surgery (404)574-5821 *(preferred)*
__ Please MAIL my records to 95 Collier Rd, NW Suite 4025, Atlanta, GA 30309 Tele: (404)574-5820

__ **Check here if you want ATL Colorectal Surgery, PC to send your records elsewhere.**
I hereby request that my medical records from ATL Colorectal Surgery be sent to:

Name of entity:_____

Telephone #:_____Fax #: _____

Entity Address:_____

**WHAT DO YOU WANT SENT?**

__ Please send my complete record over.
__ Please send specific records:
__ Preoperative Clearance (including lab results, EKG, office notes).
__ H & P/discharge summaries __ Last office note __ Colonoscopy reports
__ Operative reports __ CT scan reports __ Pathology reports
__ XRay studies __ Other reports (specify) _____

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.***

**Copies of Medical Records:** Medical records remain in the custody and control of the physician. Upon written consent, copies can be made and supplied to you or to whom you designate. You authorize us to include all information including your billing and payment history. Our office charges for copying/printing medical records according to Georgia State Law guidelines. If you are requesting records to be transferred from another doctor or organization to us, you authorize us to receive all information included in your file.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient's Name: _____Patient's Date of Birth: _____

Patient's Signature: _____ Date:_____

*This authorization may not be valid for greater than one year from the date of signature. You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written and dated request to the ATL Colorectal Surgery PC Privacy Liaison c/o Practice Manager, 95 Collier Road, N.W. Suite 4025, Atlanta, GA 30309.*