



Cleaver Medical Group
105 Professional Park Drive Cumming, GA 30040
PH: (770) 800-3455 FAX: (770) 284-8380

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS INFORMATION

PATIENT INFORMATION: (Please Print – Must be completed in ink)

Patient Name		Date of Birth		SSN
Address		City	State	Zip
				()
				Phone #

RELEASE FROM: (Name of Physician or Facility releasing information)

I authorize release of my medical records from:

Physician/Facility				()
				Phone #
Address				()
City	State	Zip	Fax #	

RELEASE TO: (Name of Physician or Facility receiving information)

Please send my medical records to:

Physician/Facility				()
				Phone #
Address				()
City	State	Zip	Fax #	

RELEASE INFORMATION:

Reason: Change of Insurance Transfer of Care Personal File
 Moving out of area Specialist Consult Legal

Please Release the following: (Check all that apply)
 Entire Record Lab/Pathology Results Only X-Ray Reports

Last visits (dates) _____

Other (please specify) _____

CONSENT:

I understand the Authorization may be revoked by written notice by myself at any time. Unless otherwise stated, this authorization will be in effect for one year past the date signed below. I understand that I may inspect and copy any written correspondence released to the above party. A photocopy of this authorization shall be fully effective and as valid for all purpose as the original hereof. I understand that once my PHI has been release it may not be covered under the Privacy rule of Cleaver Medical Group

_____ (Signature of Patient)	_____ (Date)
_____ (Signature of Witness)	_____ (Date)