FOUR CORNERS PRIMARY CARE CENTER INC.
5030 GEORGIA BELLE CT. SUITE 2066
NORCROSS, GA 30093
OFFICE: 770-806-2928 FAX: 770-806-4151

AUTHORIZATION FOR RELEASE OF INFORMATION

PatientName: _____

PatientAddress: _____

City_____State_____Zip_____
Identifier (Social Security #, Drivers License # or Other:
_____

I hereby authorize this practice to make uses and disclosure of my Protected Health Information (PHI) information about me in my medical records and/or financial records as indicated below:
To release to: (Name and address of Person or Agency receiving the information):
Four Corners Primary Care Center
5030 Georgia Belle Ct. Suite 2066 Norcross, GA 30093
To obtain from: _____
_____
_____
Description of information to be disclosed: Medical Records
_____

I understand the following:
*I may revoke this authorization at any time by providing written notice to the practice.
*I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization of the authorized was obtained as a condition of obtaining insurance coverage.
*The practice will not condition treatment or payment based on my signing this authorization.
*I am signing this authorization freely.
*The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
*I acknowledge that I have had an opportunity to review the authorization and understand the intent and use of the authorization.

_____
Patient Signature: Date:

_____
Signature of Patient Representative: Date:

_____
Title of Relationship to Patient: Expiration Date: