FOUR CORNERS PRIMARY CARE CENTERS
5300 Oakbrook Pkwy
Building 100, Suite 130
Norcross, GA 30093
Phone: 770 806-2928
Fax: 1-888-412-1761 Medical Assistant

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:		
Patient Address:		
City:	**State:**	**Zip:**
Phone:	**Date of Birth:**	
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 holding the information)		
Name:		**Phone:**
Address:		**Fax:**
City:	**State:**	**Zip:**
To obtain from: (Name and Address of Person or Agency Holding the information)		
Name:		**Phone:**
Address:		**Fax:**
City:	**State:**	**Zip:**
Description of information to be disclosed: **MEDICAL RECORDS**		
For the purpose of:		

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 or if the authorization 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 the use and have received a copy of the authorization**
- **<u>Upon taking possession of the medical records from Four Corners Primary Care Centers I agree to release FCPCC of all responsibility for the records and I will be liable if the records are lost, stolen, or left anywhere.</u>**

All information I authorize to be released from this agency will be held strictly confidential. I understand that this authorization will remain in effect for:

- □ **Ninety (90) days, unless I specify an earlier expiration date here_____**
  date
- □ **One (1) year from the date of signature.**
- □ **The period necessary to complete all transactions on accounts related to services provided to me.**

Patient Signature:	**Date:**
Signature of Patient's Representative:	**Date:**
Signature of Witness:	**Date:**
Title or Relationship to Patient:	**Expiration Date:**