PIEDMONT CANCER INSTITUTE PC AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Failure to provide all information may invalidate/void this authorization

Street Address:	Patient Name:		Date of Birth:	
Release To / Request From Release To SELF (same information as above) Release To Person/Organization:	Street Address:		MRN:	
Release To SELF (same information as above) Release To Person/Organization: Request From Address:	City/State/Zip:		Phone:	
Release To Person/Organization: Request From Address: City/State/Zip:		Release To / Re	quest From	
Request From Address: City/State/Zip:	□ Release To SELF (same inform			
City/State/Zip: Phone: Fax: Personal Insurance Continuing Care Legal Information to be released (check all that apply) Treatment Dates: From Batter Medical Record X-ray Reports History and Physician Exam Medication Records Office Notes Hospital Discharge Summary Laboratory Reports Billing Records State / Federal Laws require specific authorization to release the following types of information: Alcohol/Drug Abuse Mental Health HIV test results Delivery Instructions Hait records directly to ORGANIZATION specified Medical record copies. Relationship to patient:	□ Release To Per	son/Organization:		
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Purpose of Request □ Personal □ Insurance □ Other □ Continuing Care □ Legal Information to be released (check all that apply) Treatment Dates: From		City/State/Zip:		
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OFFICE USE ONLY	Patient Signature		Date	
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		-		
	Verified by: Driver's License DPhot			

Stockbridge Office - 1240 Eagles Landing Pkwy, Ste 260, Stockbridge, GA 30281-5173 Medical Records - 678-298-3257 Fax - 404-350-8407