

IHTI

John P. Cole, MD

1070 Powers Place
Alpharetta, Georgia 30004
(678) 566-1011
1-800-368-HAIR
Fax (678) 566-1957



Authorization for Disclosure of Health Records

(1) I, _____ authorize PHTC, Inc., to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Patient Number: N/A

Social Security Number: _____

Covering the period (s) of healthcare:

From (date) _____ To (date) _____

From (date) _____ To (date) _____

(2) Information to be disclosed:

- | | |
|---|---|
| <input type="checkbox"/> Complete health records (s) | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> History and Physical Examination | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Photographs, videotapes, digital or other images |
| <input type="checkbox"/> Other (please specify) _____ | |

Please note that a special release form needs to be signed for release of HIV results.

(3) This information is to be disclosed to _____

For the purpose of _____

(4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

(5) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Legal Representative

Date

Signature of Witness

Date