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3200 Highlands Parkway · Suite 250 ·Smyrna, Ga 30082
770-434-1904 Office 770-434-1304 fax

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMAITON

Date: _____

Patient Name: _____

Date of Birth: _____ **SS#:** (last 4 digits)_____

Facility Name: _____

Physician's Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Fax#: _____ (Please provide fax number for faster processing)

Description of Health Information to be disclosed

- O Complete Medical Record
- O Partial Medical Record (Please specify dates of service) _____
- O Labs (Please specify dates of service) _____

I hereby authorize you to release the medical record(s) of _____ to GENESIS HEALTHCARE ASSOCIATES, P.C. You may either fax or mail the records to our medical records department at (770) 434-1304, or you may mail them directly to:

Genesis Healthcare Associates, P.C.
3200 Highlands Parkway, Suite 250
Smyrna, Ga. 30082
Phone Number: (770) 434-1904

Patient/Parent Signature _____ Date: _____