1720 Reynolds St. Waycross, GA 31501 Phone: (912) 283-1359 Fax: (912) 283-1360

RECORDS RELEASE

Patient Name _____ **Provider:** _____

Date of Birth _____ **Telephone:** _____

Address _____ **City/State/Zip**_____

I authorize Elite Primary Care to release or obtain my medical information. I also give Elite Primary Care permission to speak with any physician at any time in reference to me or my medical condition.

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Release Records **TO** and/or **FROM**: (circle appropriate selection)

_____

Medical Records Requested (ex. Labs, Xray, etc.)

_____

Phone: _____ Fax: _____

Address: _____

City/State/Zip _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Elite Primary Care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the term and conditions of this authorization.

_____ _____
Signature of Patient/Authorized Rep Date

_____ _____
Witness Signature Date

12/2020