Release of Information Consent Form

1. PATIENT INFORMATION

Patient Full Name:

Patient Date of Birth: _____

2. I AUTHORIZE:

Dr. Scott Conkright
400 Plasters Ave NE, Suite 150
Atlanta, GA 30324
Phone: 404-315-7150 Fax: 801-315-7150

To release and exchange information with the following person/organization:

3. PATIENT INFORMATION

Patient's Name:

Address:

City: _____ State: _____.

Zip: _____

Phone:
_____Fax:_____

4. **INFORMATION TO BE RELEASED**

_____

5. **PURPOSE FOR DISCLOSURE:** Coordination of Care

6. **I UNDERSTAND THAT:**

My health information is protected by federal regulation and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances

I can revoke this authorization at any time.

This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
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7. **Agreement**

I, _____ , agree to the terms and conditions of these office

(Patient's Full Name)

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Patient's Signature _____

Date _____

OR Authorized Representative's Signature: _____

Date: _____

Representative's Name (printed):

_____

Representative's Relationship to Patient:

_____