Aviator Pain & Spine

304 Insperon Drive
Grovetown, GA 30813

Phone: 706-222-4559
Fax: 706-400-6493

Authorization for Release of Protected Medical Records TO Aviator Pain & Spine

Patient's Name_____ Date of Birth_____ Phone #_____

Address_____ City_____ State_____ Zip_____

To release **to: Aviator Pain & Spine, LLC Phone** 706-222-4559 **Fax:** 706-400-6493

To release from _____ Phone_____ Fax_____

Address_____ City_____ State_____ Zip_____

The purpose of this disclosure is: ___At the request of the individual __Other_____

The dates of patient care covered by this authorization are_____

Release the Following Information

___Discharge Summary	___Pathology Report(s)	___Emergency Record(s)	___History & Physical
___Radiology Report(s)	___Itemized Billing Statement	___Consultation(s)	___Lab Report(s)
___Operative Report(s)	___Cardiology Report(s)	___Progress Note(s)	___Treatment Plan(s)

___Other Records as Specified_____

__Entire Medical Record (Except for Records Concerning Highly Confidential Information).

Release of Highly Confidential Information

By checking any of the boxes next to a category of Highly Confidential Information listed below. I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated next to the line:
(*Please check all that apply – leaving a line unchecked may result in no information being disclosure for any purpose*).

__Mental Illness of Developmental Disability

__Sexually Transmitted Diseases (STD's)

___Sexual Assault

___Substance (i.e., alcohol or drugs) Abuse

___Child Abuse and Neglect

___Abuse of an Adult with a Disability

__Genetic Testing

— HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).

This Authorization Will Remain in Effect

___From the date of this authorization until _____(Not over one year)

__Until the releasing entity fulfils the request or 120 days from the date this authorization is signed, whichever occurs earlier.

I understand that

- The information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may longer be protected by applicable federal and Georgia law.
- I may refuse to sign this authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this authorization unless my treatment is research-related or I am to receive health care solely for the purpose of creating protected health information for disclosure to the recipient identified in this authorization.
- I have the right to revoke this authorization in writing at any time. The revocation will be effective immediately upon the Releasing Entity in reliance on this authorization before it received my written notice of revocation.

I have read and understand the terms of this authorization, and hereby knowingly and voluntarily authorize above Releasing Entity to use or disclose my health information in the manner described above.

_____
Patient Signature (*Parent/Guardian if under age*)

_____
Date/Time

_____
Printed Name Patient/Parent/Guardian