AUTHORIZATION TO TRANSFER MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

I hereby authorize: _____

(Previous Physicians Name or Practice Name)

Phone #: _____

Fax#: _____

___To release **ALL** of my medical information, including any mental condition, treatment or physical condition to:

___ Only the following records or types of health information: _____

Premier Medical Associates PC
407 East Maple Street, Suite 101
Cumming, GA 30040
Phone: 770-888-6697 Fax: 877-892-0151
Dr. Ludy Lukose, M.D

I understand that this authorization will automatically expire one year for the date of my signature, and that I may revoke this authorization by sending in written notice to the person on entity authorized to make the disclosure described above. I agree that any release made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. **Note: This Authorization does extend to HIV test results, outpatient psychotherapy notes, drug and alcohol treatment records that are protected by federal law, or mental health records.**

I authorize the release of my Medical Records

Patient Signature: _____ Date: _____

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____

Name of Guardian/Representative Relationship Date Witness