Whitefoord, Inc.
Uniting Community through Health and Education

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please fill this page out if you would like to release your healthcare information to Whitefoord Family Medical Center

Patient Name: _____ **Date of Birth:** _____/_____/_____

Social Security Number: _____

I request and authorize _____ **to release healthcare information of the patient named above to:**

Whitefoord Family Medical Center
30 Warren Street
Atlanta, GA 30317
Phone: (404) 373-2282 Fax: (404) 373-2926

This request and authorization applies to:

Healthcare information relating to the following treatment, conditions or dates:
_____

☐ All healthcare information relating to the above OR

- ☐ Records only
- ☐ Lab results and X-ray/Radiology Reports
- ☐ Consultant Notes
- ☐ Other: _____

I authorize the release of STD and HIV/AIDS results whether negative or positive. I understand that Whitefoord Family Medical Center will be notified that I must give specific written permission before disclosure of these test results to anyone. ☐ Yes ☐ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to Whitefoord Family Medical Center. ☐ Yes ☐ No

I understand that I have the right to withdraw this consent at any time upon written notice to the Whitefoord Family Medical Center Director.

_____ _____/_____/_____
Patient Signature **Date**

_____ _____/_____/_____
Parent/Guardian Signature **Date**

This Authorization Expires 180 Days After It Is Signed