Karen R. Maffei, M.D.

1050 Thomas Avenue, Watkinsville, GA. 30677 phone (706) 769-1550 fax (706) 769-1514

Authorization Release of Medical Information

Patients name: ____ Date of Birth: ____________________

Address: ____

City/State/Zip Code: ____

Date of Request: ________________

○ **I authorize Dr. Karen R. Maffei to release information to**

OR

○ **I authorize Dr. Karen R. Maffei to obtain information from:**

____
Name of Provider or Facility

____
Phone#/Fax #

CONSENT FOR RELEASE OF MEDICAL INFORMATION INCLUDING, IF ANY, HIV, AIDS, PSYCHIATRIC, AND SUBTANCE ABUSE

- I hereby authorize the above Physician/hospital/facility to release information including, if any, psychiatric or psychological information, infections or contagious disease information (including HIV/AIDS) and or information about drug or alcohol abuse or treatment of the same from the health record.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

To release my:

○ **Complete Medical Record last three years Office Notes, Lab Reports, and all Radiology studies.**

○ **Other As follows:**
____

Patient Name ___________________________________ **Witness:** ___________________________________

Patient/Legal Representative Signature: ______________________________ **Date:** __________________________

Date at which this request will expire: ____________________

APPROVED: ______________