REQUEST FOR RELEASE OF INFORMATION

I hereby authorize use and/or disclosure of protected health information (PHI) about me as described below. By signing, I authorize

____(Practice/ Doctor Name)

____(Address)

____(Phone/ Fax)

to disclose certain PHI about me to: High Mountain Healthcare LLC
63 Pleasant Hill Rd. Blairsville, GA 30512
Phone: 706-745-2229 Fax: 706-745-0836

****From the past year only****

______ Radiology reports
______Labs
______Hospital discharge records
______Growth charts & immunizations (if children)
______Special studies (stress tests, cardiac caths, ekg, ect.)
______Office notes

****If you are sending more than 20 pages, please mail to the above address****

This information will be used or disclosed to aid in the diagnosis and/or continuing treatment of the patient.

I may revoke this authorization by notifying the provider named above in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign it.

This authorization expires one year from date signed, or upon written notice of cancellation by me to the provider.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

_______________________________ _______________________________
Print patients name Print legal guardians name if applicable

____
Patient Date of Birth

_______________________________ _______________________________
Patient or legal guardians signature Date

Parent/Guardian must be provided with a signed copy of this authorization form.