Bibb Family Practice Associates, PC
Sam G. Amporful, M.D.
721 RIVERSIDE DRIVE LANE
MACON, GA 31201
(478) 259-3439

PATIENT RELEASE OF INFORMATION

I authorize Bibb Family Practice to discuss the medical treatment, results of any labs or x-rays or other procedures with the following individual(s) such as spouse or (Parents please note that the person that you authorize to bring in your child will have to present a picture ID at the time of visit.)

Name	Relation	Phone Number

This authorization will remain in effect until the following date(s): _____

_____ _____
Signature of Patient or Legal Representative **Date**

If signed by Legal Representative;

_____ _____
Relationship to Patient (authority to act on patient's behalf) **Date**

<u>Purpose for Need of Disclosure: At the release of the individual</u>

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.
I understand I have the right to:

- Receive a copy of this authorization
- Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for healthcare benefits may not be contingent on my signing this authorization.

Revoke this authorization, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this.

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MEDICAL RECORD RELEASE AUTHORIZATION

Patient Name_____ **Maiden Name**_____ **SS#**_____

Date of Birth_____ **Home Phone** _____ **Cell/Work**_____

Address_____ **City/State/Zip**_____

Email Address_____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone_____ **Fax**_____

A) To be released TO:

Name: Bibb Family Practice

Address: 721 Riverside Drive Lane

City/State/Zip: Macon, GA 31201

Phone 478-259-3498 **Fax** 478-254-2733

C) For the purpose of:

_____**Continuity of Care/Transfer of Care**
_____**Self/Personal Copy** _____**Litigation**
_____**Insurance** _____**Disability**
_____**Work Comp** _____**Other**

STAT

Date Range_____**to**_____
☐**Physicians' Office Notes** ☐**Cardiology/EKG Reports**
☐**Immunizations** ☐**Lab/Path Reports**
☐**Operative/Procedure Reports** ☐ **Radiology/Xray/MRI**
☐**Other**_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re- disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ ****Subject to Fees**
(Date) **Signature of Patient/Parent/Guardian or Authorized Representative)**

This authorization will expire one year from the above date unless I specify an expiration date:

_____
(Expiration date of authorization)

*Fee Information: We reserve the right to charge the fee schedule as set by the State of Georgia. A $25.88 handling fee, $0.97 per page, and postage will be invoiced to you from Bibb Family Practice with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to Bibb Family Practice for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.