FACILITY: LMG
MR# 1901970

APR 29 2021

REQ CODE: PAT
B NB CERT

LAUREATE MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Name of Patient: Justin odom

Address: 217 Howell chase
Duluth, GA 30096

Phone #: 901-524-9672

Patient's Date of Birth: 3/1/1982

Laureate Medical Group identified above is hereby authorized to (Please mark appropriate box):

☒ Release to OR ☐ Receive from the following person(s) or entity(ies) or class of person(s) or entity(ies) (Please identify by name or facility and indicate address or fax to send to): Justin odom

Address: 217 Howell chase Duluth, GA 30096

Fax:

The following protected health information regarding the patient (Please mark appropriate box(es)):

☒ Complete Medical Record ☐ Abstract of Medical Record (physician dictated reports & diagnostic reports)

☐ Labs only ☐ Radiology only ☐ EKG only

☐ Other (Please specify clearly) _____ For the following dates of service: _____

Unless you state otherwise, this authorization includes the release and disclosure of all medical records and information, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization includes the release of any information regarding treatment or referral for substance abuse, including drugs and alcohol, except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a different consent form is required.

Unless you state otherwise by marking one or both boxes below, this authorization includes the release and disclosure of records and information which may include (i) HIV/AIDS confidential information and/or (ii) privileged mental health communications between the patient and a mental healthcare provider, and you affirmatively waive any protections from disclosure that might otherwise apply. HIV/ AIDS confidential information is defined by Georgia law to include the fact that a patient has had an HIV test or been counseled about HIV, even if the test is negative. NOTE: Unless otherwise permitted by law, the release of HIV/AIDS confidential information and/or privileged mental health communications can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I object to the release of HIV/AIDS confidential information.

☐ I object to the release of any privileged mental health communications under Georgia law.

The purpose of the requested disclosure is (Please describe each purpose of the requested use or disclosure):

The purpose of the requested disclosure is (Please describe each purpose of the requested use or disclosure):

submit to insurance for short term disability

H I M Q S
ROI REP: AM PAGES: 27

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DOS: 12/9/20 - 4/7/21
ENT ABS PerReq