3833 Roswell Road
Suite 116
Atlanta, Georgia 30342

HOLISTIC MEDICAL SERVICES, INC.

FRANK P. MATALONE, D.O., N.M.D.

Phone: 404-941-8621
Fax: 404-549-3005
Supplements: 404-941-8625

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
MEDICAL RECORDS RELEASE FORM

Patient's Name: _____ Date of Birth: _____

I do hereby request and give permission to release my Medical Records for the following time period listed below:

All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify):

_____

All information regarding care received
by patient between the dates of _____ and _____
Starting Date Ending Date

Other Information (specify): _____

From the following Medical Clinic:

Name: Holistic Medical Services

Address: 3833 Roswell Road NE, Suite 116

City: Atlanta State: GA Zip: 30342

Office Phone: 404-941-8621 Office Fax: 404-549-3005

Please release the above mentioned Medical Records to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

Authorization

_____
Printed name of Patient or Authorized Representative

_____ _____ _____ _____
Signature of Patient or Authorized Representative Date Signature of Witness Date

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If not signed by the patient, indicate authorizing person's relationship to the patient:

Parent or guardian of minor child
Guardian or conservator of conserved patient
Beneficiary or personal representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	To
_____	_____	Alcohol or Drug Use/Abuse Treatment	_____	_____
_____	_____	Mental Health Treatment	_____	_____
_____	_____	HIV Status or Treatment	_____	_____

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and received a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that has been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your healthcare provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.