DEKALB SURGICAL ASSOCIATES, P.C.

2665 N. Decatur Rd. Ste. 730
Decatur, GA 30033
404.508.4320
Fax 404.508.4112

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ____, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient name: ____Date of birth: ________________

Release information to: **DeKalb Surgical Associates, P.C.**

Address: 2665 N. Decatur Rd. Ste. 730 Decatur, GA 30033 **FAX: 404.508.4112**

I consent to have the following medical information released:

_____ Entire medical record

_____Operative Reports

_____Pathology Reports

_____Lab Reports

_____Radiology Reports

_____Other____

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment

This consent permits the Practice to use and disclose my health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

____ (Print patient's name)

____ (Signature of patient) Date: _______________

____ (Signature of legally authorized person)