AUTHORIZATION AND CONSENT TO RELEASE MEDICAL RECORDS

I, the undersigned patient/guardian, hereby authorize Atlanta Center for Athletes to release the information listed below from the records of _____. I understand this authorization for release of medical records includes the release of HIV records, Psychiatric Mental Illness and any other statutory protected diseases.

PLEASE CHECK APPROPRIATE ITEM(S):

_____ Medical Records

_____ MRI Films and Report

_____ Operative Report

_____ X-rays (Specify which x-rays are requested)

_____

_____

REASON FOR REQUEST:

_____ Copy for Personal Use

_____ Copy for Another Physician*

_____ Second Opinion for Surgery*

_____ Second Opinion for W/C*

_____ Copy For Attorney

*Please provide physician name.

_____

*Provide appointment date for second opinion.

_____

Name of Adjuster _____

Adjuster Notified ☐ Yes ☐ No Date: _____

Party To Whom Records Should Be Sent:

Name:_____

Address:_____

_____

Phone#:_____ Fax#:_____

_____ _____
Signature of Patient/Guardian Date of Signature

_____ _____
Relationship To Patient Patient's Date of Birth

_____ _____
Daytime Phone Number Patient's Social Security Number

If additional information is needed, you will be contacted by the Medical Records Custodian.

Requests for x-rays/MRI films may take 7-10 days to process. Requests for medical records may take up to 4 weeks. Due to the large volume of requests, all requests are processed in the order in which they are received. Thank you for your patience.
FAX NUMBER: 770-622-0315