

ATLANTA PODIATRY, P.C.
4355 Johns Creek Parkway, Suite 520
Suwanee, GA 30024
Phone: 770-418-0456
Fax: 770-418-1603

AUTHORIZATION FOR REQUEST OF INFORMATION

Section A: Must be completed for all authorizations

I hereby request medical records for the following individual(s). I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient name: _____

Date of birth: _____

Persons/organizations receiving the information: Atlanta Podiatry, P.C.

Specific description of information to be used or disclosed (including date(s)) : _____

SECTION B: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

The patient or the patient's representative must read and initial the following statements.

1. I understand that I may revoke this authorization at any time by notifying Atlanta Podiatry, P.C. in writing, but if I do it won't have any effect on any actions taken before receipt of my revocation

**Initials:* _____

* _____
Signature of patient or patient's representative
(form MUST be completed before signing.)

* _____
Date

*Printed name of patients's representative (if applicable): _____

*Relationship to the patient (if applicable): _____

*******YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*******

Jill K. Stepnicka, DPM
Rupal P. Gupta, DPM