NORTH GEORGIA NEUROLOGICAL CLINIC, P.C.

NEUROLOGY ▪ ELECTROMYOGRAPHY ▪ ELECTROENCEPHALOGRAPHY

YAZAN HOUSSAMI, M.D. M. TODD WILLIAMSON, M.D. DAVID A. KRENDEL, M.D.

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Date: _____

I hereby authorize:
North Georgia Neurological Clinic, P.C.
Phone: 770-995-0555
Fax: 770-995-0682

To: ☐ **Release information to** ☐ **Obtain information from**
☐ **Talk face to face/via phone** ☐ **Other**_____

Facility / Provider name: _____
Address: _____
_____
Phone: _____
Fax: _____

Information requested: ☐ **Office notes** ☐ **Lab results** ☐ **Radiology results**
☐ **All records** ☐ **Other**_____

I hereby understand and authorize the release of the above-selected medical records or other information which may include information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization or quality assurance activities.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization at any time.

_____ _____
Signature of Patient / Legal Guardian Patient's Date of Birth

_____ _____
Print Patient's name Relationship to patient, if not patient

Patient unable to sign due to: _____