Phone: 678-626-1868 Fax: 678-626-1898
Email: info@northviewwellness.com

Authorization for Release of Records

In order to release or obtain your records, all of the following information must be provided. If any information is left blank, your request will not be processed.

Patient Name _____ Date of Birth _____

Address _____

Phone Number _____

Are you transferring out of our facility? Yes No

I Authorize Northview Wellness PC to:

_____ Obtain my records from: _____ Release my records to: _____ Discuss my care with:

Facility/Doctor/Person Name _____

Address _____

Phone # _____ Fax # _____

I hereby consent to the release of all medical Records and other Documentation pertaining to the medical care received in this Facility, including the following:

_____ All Treatment (Last 2 years unless otherwise specified)

_____ Lab Reports/X-ray Reports

_____ Treatment related to specific injury or illness

Dates of Treatment: Beginning Date _____ Ending Date _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment. I understand that I may revoke this authorization, in writing, at any time, except to the extent that records have already been released. I understand that I do not have to sign this authorization in order to get healthcare treatment.

Patient Signature _____ Print Name _____

Date _____