Horizons Diagnostics, L.L.C.

3934 Woodruff Road
Columbus, Ga 31904
706-322-0304

Authorization to Release Medical Information

Patient Name: _____ **DOB:** _____

Address: _____

I hereby authorize: _____

Address: _____

to release information from my medical record to:

Horizons Diagnostics, L.L.C.
3934 Woodruff Road
Columbus, Ga 31904
ATTN: Dr. _____

This information will be disclosed for the following purposes. (This item is not required if the disclosure is requested by the patient.) _____

The information to be released is:

- ☐ Discharge Summary
- ☐ X-Rays
- ☐ Cardiovascular
- ☐ Consultation
- ☐ Pathology
- ☐ Other (Specify)_____
- ☐ Laboratory
- ☐ Scans
- ☐ History & Physical
- ☐ Operative Report
- ☐ Progress Notes
- ☐ ALL

Special Authorization: Release of Mental Health, Alcohol or Drug Patient Records

(If patient is less than 14 years of age, a parent or guardian must sign.)

Check box if this information is to be released:

☐ My diagnosis and/or treatment for alcoholic and/or drug abuse or dependence may be released to the recipient noted on the consent above.

☐ My diagnosis and/or treatment concerning my mental health/rehabilitation may be released to the recipient noted on the consent above.

☐ My diagnosis and/or treatment for AIDS/HIV testing may be released to the recipient noted on the consent above.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information used/ disclosed under this authorization. (This item is not required if the disclosure is requested by the patient.)

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it.

I understand that this consent will expire three months after the dated signature.

Patient Signature Date

Witness Signature Date

If patient is unable to give consent because of physical condition or age, complete the following.
Patient is:

_____ a minor (_____ years of age)
_____ unable to give consent because: _____

Signature of Guardian/ Representative Relationship Date