The Stevens Clinic

405 S. Thornton Ave.

PO Box 1927

Dalton, GA 30722

Ph. 706-226-1146 Fax 706-226-1483

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name ____ Date of Birth ___________________

Social Security Number ____________________________

I hereby authorize ____

to release to ____

the following information: ____

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I understand that my personal health information and medical records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent, except as otherwise provided in these regulations. I also acknowledge that The Stevens Clinic's Notice of Privacy Practices has been made available to me and that I may request my own personal copy. I further understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance upon it. Unless otherwise revoked by this notice, this authorization for release of information will expire in one (1) year from the date indicated below.

Signature of Patient ______________________________________ Date ______________________

Signature of Guardian_____________________________________ Date _____________________

Signature of Witness ______________________________________ Date ______________________