Fine & Associates

Internal Medicine Specialists, P.C. – Joel L. Fine, M.D.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	**Date of Birth:**	**Patient's Phone:**
Recipient's Name:	**Recipient's Phone:**	**Relationship to Patient**

Please note most physicians only need the most recent year of medical records which will be provided to you free of charge. If your physician indicates they need additional records, please fax an additional request - additional records are provided but fees may be incurred per Georgia Statute O.C.G.A $31-33-3

		Current
Search, Retrieval, and Other Direct Administrative Costs	Up To:	$25.88
Certification Fee	Up to per record:	$9.70
Copying Costs for Records in Paper Form	Per page for pages 1 – 20:	$0.97
	Per page for pages 21 – 100:	$0.83
	Per page for pages over 100:	$0.66

Records requests can be faxed to: 855-656-6472	**Comments:**
or mailed to: Eastside Medical Group **Snellville, GA 30078** **1700 Tree Lane, Suite 390**	

Method of Delivery:

☐ **Fax to my Doctor's office** _____ _____

Physician Name **Fax Number**

☐ **Mail to my home** _____

Street Address **City** **State** **Zip**

I have read the above and authorize the disclosure of the protected health information:

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

After June 9th, for questions please call 678-639-3978