Complete Family Medicine, LLC
6084 Professional Pkwy., Ste. C
Douglasville, GA 30134
Phone: 770-942-1440 Fax: 770-942-2929

Permission to Release Information

I, ______________________________ do hereby acknowledge that I designate the
Patient's printed name
people listed below as authorized contacts to speak with and/or release the information below:

Name: __________________________ Relationship: _______________________

Name: __________________________ Relationship: _______________________

Name: __________________________ Relationship: _______________________

Regarding My:

- Appointments
- Bills/Statements
- Physician Instructions
- Medical info/ Results

This is/ (these are) the only person(s), other than myself, that I authorize to be given this information.

I certify my understanding that medical information is considered to be confidential and that when employees or others associated with Complete Family Medicine, LLC are discussing my case over the phone, there is not a way of being able to verify that they are talking with the above-designated person. Therefore, I hold harmless and blameless any person who states that they are (one of) the designee(s) listed above.

Re: Medical info/results: I am requesting this in an attempt to prevent having to make an office appointment for the sole purpose of obtaining test results. *(Please be aware that results only will be given over the phone. No discussion or interpretation will be offered regarding those results. An appointment must be made with the doctor for interpretation. I further understand that there are some test results that will not be given over the phone and that I must make an appointment for those test results.)*

I have had an opportunity to have any questions related to this form answered by the office staff.

This authorization will remain valid until revoked by me in writing.

Signature: ______________________________ Date: ______________________