

**Sugarloaf Medical P.C.**  
General Internal Medicine – Primary Care

**Authorization to Disclose / Transfer Health Information**

I, the signed patient or legal guardian of patient authorize

\_\_\_\_\_  
(Name of Physician, Medical Practice, or Treating Hospital)

\_\_\_\_\_  
(Address of Facility)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

\_\_\_\_\_  
(Telephone #)

\_\_\_\_\_  
(Fax # - Very Important)

To release medical / health information listed below from the records of:

\_\_\_\_\_  
(Name of Patient)

\_\_\_\_\_  
(Date of Birth)

For the following services:

- Medical Summary
- Major Diagnostic Procedures (Ct-scan, Stress Test, EGD, Colonoscopy...)
- Recent Lab Results
- Entire Medical Record
- Hospitalization / Date \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

- I acknowledge that the medical information released may include all treatments of physical and mental illnesses, drug/alcohol abuse, and past medical history.
- I know I am fully responsible for the fees, if any, brought by this request.
- I understand that my authorization will expire within one year from today and that I may revoke this authorization earlier in writing (this revocation will not apply to information that has already been released.)
- I understand that this consent has no bearing on the ability of this office, and its right to consent a claim with my insurance.

I authorize the information to be disclosed to and used by:

**Sugarloaf Medical P.C**  
**1300 Peachtree Industrial Blvd. Unit 4203**  
**Suwanee, GA 30024**  
**Phone# (770)831-3018      Fax :( 770)-831-3669**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Print Patient Name Date

\_\_\_\_\_  
Date