TAMARA Y. BROWN, MD, LLC
5835 Campbellton Road SW
Suite 201
Atlanta, GA 30331
Phone: (404) 696-4141/ Fax: (404) 696-4166

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

Patient _____ D.O.B _____
S.S.N _____

I do hereby authorize:

Tamara Y. Brown, MD, LLC
5835 Campbellton Road SW
Suite 201
Atlanta, GA 30331

To Release: □ Office Notes □ Physical Reports □ Lab Reports □ Pathology Reports
□ Ultrasound Reports □ Mammogram Reports □ Pap Smear Reports □ All Records
□ Other_____

To:

_____
Name of Physician

_____
Address City State Zip Phone Fax

Medical Records Copying Charges

If you need a copy of the requested information for personal use, pursuant to the Official Code of the State of Georgia (O.C.G.A. 31-33-3), Tamara Y. Brown, MD, LLC charges a fee for costs related to medical record retrieval, certification, and copying to the person or entity making the request. Payment for all requested information is due prior to release/disclosure. The fee for personal use copy is $50.00. The rights granted by this regulation do not grant a patient or person any right of ownership of the records, as such records are owned by and are the property of Tamara Y. Brown, MD, LLC.

If the requested information is being sent to a physician's office, as a courtesy to the physician, we will send the requested information at no charge.

Some of the information in the requested Medical Records may be of a sensitive nature. By signing this release, I am granting permission for the information pertaining to the below mentioned areas to be released. I waive any privilege or confidentiality existing under Federal or State Law regarding such information, including, but not limited to, protection afforded to:

(1) Communications made to a Psychiatrist (O.C.G.A. 24-9-21)
(2) Communications made to a Licensed Applied Psychologist (O.C.G.A. 43-36-16)
(3) Medical Information concerning alcohol and drug dependency (O.C.G.A. 37-1-166)
(4) Medical Information regarding mental illness (O.C.G.A. 37-3-166)
(5) Medical Information concerning alcohol and drug abuse (42-C.F.R. Part 2)
(6) AIDS confidential information (O.C.G.A. 31-22-9 and 24-9-47)

Patient Name:_____

Signature:_____ **Date:** _____