WOODSTOCK PRIMARY CARE

3353 Trickum Road, Suite 201
Woodstock, GA 30188
P: 770-591-4777 F: 770-591-4795

(Please Mail if more than 10 Pages)

Ilya Wolfson, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize use and/or disclosure of protected health information (PHI) about me as described below. By signing, I authorize Ilya Wolfson, M.D. to receive certain PHI about me from:

Former PCP:_____
Ph/Fax:_____
Urology:_____
Ph/Fax:_____
Cardiology:_____
Ph/Fax:_____
Dermatology:_____
Ph/Fax:_____
Surgeon:_____
Ph/Fax:_____
Nephrology:_____
Ph/Fax:_____
Pulmonary:_____
Ph/Fax:_____
Psychiatry:_____
Ph/Fax:_____

OB-GYN:_____
Ph/Fax:_____
Podiatry:_____
Ph/Fax:_____
Orthopedic:_____
Ph/Fax:_____
Neurology:_____
Ph/Fax:_____
Gastroenterology:_____
Ph/Fax:_____
Pain Specialty:_____
Ph/Fax:_____
Oncology:_____
Ph/Fax:_____
Rheumatology:_____
Ph/Fax:_____

____ Complete health record for the previous year, including drug, alcohol, mental health, STD, HIV/AIDS results.

____ Laboratory, Radiology, Diagnostic results.

____ Health information relating to treatment, condition, dates:_____

I may revoke this authorization by notifying the provider in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to who this authorization is furnished may not condition its treatment of me on whether or not I sign it.

This authorization expires one year from today _____, 20____, unless specified by me to the provider.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Patient or Legal Guardian Signature Date