MELISSA BLACK, M.D.
Phone 404-981-6278
Fax 888-213-8479
mpblackmd@empowerdecatur.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____

Date of Birth: ____

Previous Name: ____

I authorize:

____

____

to release healthcare information of the patient named above to:

Melissa Black, M.D.
Fax: 888-213-8479

This request and authorization applies to:
❒ Healthcare information relating to the following treatment, condition, or dates:

____

❒All healthcare information
❒ Specifically:
❒ Most recent provider progress notes, past ______ months
❒ Health maintenance record
❒ Hospital H&P, Specialist consult notes, and discharge summary
❒ Lab reports
❒ Imaging results including ❒ radiology report ❒ films in digital format
❒ Cardiac testing results including stress test, nuclear imaging, EKG and echocardiogram
❒ Surgical report, Operative Note, or Cardiac Catheterization note
❒ Most recent physical, occupational and speech therapy note including swallow study
❒ Procedure notes including endoscopy, nerve conduction study, pulmonary function study
❒ Pathology reports

❒ Other:

❒ Yes ❒ No I authorize the release of my STD* results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

❒ Yes ❒ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

*Sexually Transmitted Disease (STD) includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient Signature: ______________________________ Date signed: ______________