Alise Jones-Bailey, M.D.
Buckhead Functional Medicine
General Medical Records Release and
Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____ Date of Birth: _____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

☐ All records
☐ Laboratory/pathology records
☐ X-ray/radiology records
☐ Billing records
☐ Abstract/Summary
☐ Pharmacy/prescription records
☐ Other (describe specifically)

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s):

Please send the records listed above to (use additional sheets if necessary):

DR. ALISE JONES BAILEY/BUCKHEAD FUNCTIONAL MEDICINE
3193 HOWELL MILL ROAD, SUITE 316
ATLANTA, GA 30327
(p) 678-428-1653 (f) 404-228-7135

The information may be used/disclosed for each of the following purposes:

☐ At my request
☐ For my health care
☐ For payment/insurance
☐ For employment purposes
☐ Other:

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

Printed name of patient representative	Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written