RELEASE OF CONFIDENTIAL INFORMATION FORM

Patient confidentiality is a priority at Atlanta ID Group. Therefore, it is important that you provide us with the following information to ensure your privacy.

In the event that I,_____ (print your name here), am unable to be reached, Atlanta ID Group has my permission to leave my test results or lab results in the following manner(s) - Please check all that apply:

☐ Spouse/ Significant other:_____

☐ Children – Name(s) _____
(Over age of 18)

☐ May call or leave message on voicemail at/on

☐ Home phone: _____

☐ Cell phone: _____

☐ Work phone: _____

☐ Other option/person – Name(s):_____

Please list any family members (including spouse), or friends you authorize to receive information on your medical condition (e.g. test results, hospital status appointment information etc.) or billing information.

Complete the information below to authorize release of information

☐ I, _____, give Atlanta ID Group
(Print full name of person signing)

Permission to release medical/billing information to the following persons:

Name Relationship Phone _____

Name Relationship Phone _____

Name Relationship Phone _____

☐ I, _____, do not give Atlanta ID Group
(Print full name of person signing)
permission to release medical/billing information.

Signature: _____ Date:_____
(If patient is a minor, then a parent or legal guardian must sign.)