Alpharetta Family Medical Clinic 10800 Jones Bridge Road, Suite A, Alpharetta, GA 30022 Tel: (678) 867-0135, Fax: (678) 867-0137

AKNOWLEDGE/AUTHORIZATION/CONSENT

Dationt's Name (Blasse Drint)		Data of Birth
Patient's Name (Please Print)	SS#	Date of Birth
Address Street City Zip	Home Phone	Work Phone
Privacy Policy Ac	knowledgement Statement	
I hereby acknowledge that I have been m Clinic has a privacy policy in place in ac and Accountability Act of 1996 (HIPAA	cordance with the Health Ins	
Patient signature (or Parent/Guardian	n if Patient is a Minor)	Date
AUTHORIZATION FOR	R RELEASE OF INFORMA	ATION
treatment of chemical dependency and/or alcoho infectious disease, such as Acquired Immunodeficiency Syndr Tuberculosis; or Hepatitis. I authorize such releathe conditions and for the purpose as stated below 1. Name of person(s) and/or organization(riciency Syndrome (AIDS); Human rome Related Complex (ARC); Ve ase to the person or organizations l w:	n Immunodeficiency nereal Disease; isted below and under
☐ Health Insurance Company (for the purpose		
□ Pharmacy (for the purpose of prescription call in and refill medication)		
☐ Physician(s) (for the purpose of referral and treatment)		
Others		
☐ Authorization for release of medical record	to Alpharetta Family Medical Cl	inic
2. Purpose and need for disclosure:		
ig ⁿ		
Patient signature (or Parent/Guardian	n if Patient is a Minor)	Date