REQUEST FOR RELEASE OF MEDICAL RECORDS

Complete & Fax to: 470-704-4378

Attn: Medical Records
Wellvia, Inc dba Dr. Smith's Program
1340 Center Dr, Suite 103
Atlanta, GA 30338
phone 770.438.8446

I. Patient Information. Circle **all** locations **where you were seen:**

Sandy Springs Lawrenceville Riverdale Virtual

Print your Name: _____

Previous Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

SSN: _____ Date of Birth: _____

II. **Authorization for Release.** I hereby authorize Wellvia, Inc to release, disclose, and deliver the medical information described below to:

What would you like released? _____

Circle how the records should be sent? By Mail By Fax Pick up in Person

Print who should receive these records: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

********* **ALLOW AT LEAST 4 WEEKS FOR RECORDS TO BE READY** **********

III. **Specific Authorization.** I specifically authorize the release of all medical information relating to me (the above named patient) including, but not limited to, the following categories protected by state or federal law: 1) Substance Abuse (drug or alcohol) treatment, 2) Mental health treatment, 3) HIV-AIDS-related information, 4) medical/surgical, if such information is contained in my records. This request includes any and all materials in possession of Wellvia, Inc, whether originating from this company or from any company acquired by Wellvia, Inc. I hereby release Wellvia, Inc and its employees from any liability which may result from disclosure of this confidential medical information, or which may arise as a result of the use of the information released. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire 90 days from the date signed. I authorize that this information may be faxed to the requesting party.

Patient's Signature: _____ **Date**: _____