



**DE SILVA**  
MEDICAL GROUP

**DE SILVA MEDICAL GROUP, PC.**  
**PO Box 479, Villa Rica, GA 30801**  
**844-475-3922 | 404-949-1848 fax**  
[www.desilvamedgroup.com](http://www.desilvamedgroup.com)

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**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

**Patient Information**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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**1. Information to Be Released TO:**

De Silva Medical Group, PC  
PO Box 479, Villa Rica, GA. 30801  
Fax: 208-949-1848

I hereby authorize the release of my medical records to De Silva Medical Group, PC from:

Name of Provider/Facility Releasing Records:

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Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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## 2. Description of Information to Be Disclosed

(Select all that apply)

- Complete Medical Record
  - Office Visit Notes
  - Lab Results
  - Radiology/Imaging Reports
  - Immunization Records
  - Medication List
  - Surgical/Procedure Reports
  - Other (specify): \_\_\_\_\_
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## 3. Purpose of Disclosure

- Continuity of care
  - Personal use
  - Legal
  - Insurance
  - Other (specify): \_\_\_\_\_
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#### 4. Authorization & Rights

I understand that:

- This authorization is voluntary and I may revoke it at any time by submitting a written request to the releasing provider, except to the extent that records have already been released.
- My treatment, payment, or eligibility for benefits will not be conditioned on signing this form.
- Records disclosed may include information regarding mental health, substance use, HIV/AIDS, or other sensitive conditions unless specifically excluded here:
  
- Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

#### 5. Expiration of Authorization

This authorization will expire on:

One year from the date of signature

or

Other date/event: \_\_\_\_\_

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#### 6. Signature

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PATIENT/LEGAL GUARDIAN SIGNATURE

PRINTED NAME

DATE