WOODSTOCK PRIMARY CARE
3380 Trickum Road,
Bldg 1000, Unit102
Woodstock, GA 30188
P: 770-591-4777 F: 770-591-4795
(Please Mail if more than 10 Pages)

Ilya Wolfson, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize use and/or disclosure of protected health information (PHI) about me as described below. By signing, I authorize Ilya Wolfson, M.D. to receive certain PHI about me from:

Former PCP: _____
Ph/Fax: _____
Urology: _____
Ph/Fax: _____
Cardiology: _____
Ph/Fax: _____
Dermatology: _____
Ph/Fax: _____
Surgeon: _____
Ph/Fax: _____
Nephrology: _____
Ph/Fax: _____
Pulmonary: _____
Ph/Fax: _____
Psychiatry: _____
Ph/Fax: _____

OB-GYN: _____
Ph/Fax: _____
Podiatry: _____
Ph/Fax: _____
Orthopedic: _____
Ph/Fax: _____
Neurology: _____
Ph/Fax: _____
Gastroenterology: _____
Ph/Fax: _____
Pain Specialty: _____
Ph/Fax: _____
Oncology: _____
Ph/Fax: _____
Rheumatology: _____
Ph/Fax: _____

Complete health record for the previous year, including drug, alcohol, mental health, STD, HIV/AIDS results.

Laboratory, Radiology, Diagnostic results.

Health information relating to treatment, condition, dates:._____

I may revoke this authorization by notifying the provider in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires one year from today _____ 20___, unless specified by me to the provider.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Patient or Legal Guardian Signature Date