The Fountainview Center for Alzheimer's Disease
2631 North Druid Hills Rd. N.E.
Atlanta, Georgia 30329
(404) 325-7994
(404) 325-1213 – Fax
www.thefountainviewcenter.com

Authorization for the Release of Health Information

I hereby authorize _____(the facility/doctor) to disclose my individually identifiable information as described below.

A. _____
Patient Name Social Security Number Date of Birth

B. Name & Address of Responsible Party(s):

C. Name & Address of person(s) or Organization (s) to receive the records:

The Fountainview Center
2631 North Druid Hills Rd. NE
Atlanta, Georgia 30329
(404) 325-7994 phone
(404) 325-1213 fax

I am requesting that the facility, hospital, physician, etc. complete the DMA-6, History and Physical, Level I form and Chest X-ray or PPD, and send the records to the above address or fax the records to the above fax number. The records will be used for review for possible admission to The Fountainview Center for Alzheimer's Disease and are necessary for admission.

Additionally, please forward any of the following information (that may be applicable) from the last quarter (or most recent visit) for review.

_____ Nursing Notes _____ X-Ray Reports _____ PT/OT/SLP Records (eval and last week only)

_____ Lab Results _____Discharge Summary

_____ Physician Orders _____ Medication Adm. Record _____ DNR status (if available)

_____ Physician Progress Notes _____ IV medication/fluid records _____ Other

Legal Authority for Request

I am the resident's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the resident's medical records. If a DPAHC is attached, then I have also included evidence that the resident's attending physician has determined that the resident has lost the capacity to make informed health care decisions.

_____ _____
Signature of Responsible Party Date