AV8RMED
SERVING THE PROFESSIONAL PILOT

Authorization for Use and Disclosure of Protected Health Information

With my consent, I, (Printed Name): _____, hereby request and authorize AV8RMED to furnish medical information to **Dr.** _____located at
Address: _____
Phone number: _____ **Fax number**: _____

Any and all information may be released, including, but not limited to, mental health records protected by the Lanterman- Petris – Short ACT, drug and alcohol records, and HIV test results, if any, except as specifically provided below:

_____

_____

I understand and agree to pay a reasonable charge to cover the transfer cost. Pursuant to O.C.G.A 31-33-3, I understand the costs will be computed based on a copying fee per page for standard documents, actual costs for the reproduction of oversized documents or documents requiring special processing, and reasonable clerical costs for locating and making the records available.

By signing this form, I consent to AV8RMED, LLC's use and/or disclosure of my PHI with the FAA-OAM Aerospace Medical Certification Division (AMCD) and other treating providers to assist in determining my fitness for flight and medical certification.

This authorization will expire within two (2) years from the date listed below.

_____	_____	_____
Date	Signature	Date of Birth

_____
Parent/Guardian Name

100 Hartsfield Centre Parkway, Suite 340, Atlanta, GA 30354
Tel: 404.565.0870 | Fax: 404.565.0879 | info@av8rmed.com
www.av8rmed.com