2451 Cumberland Parkway SE, Suite 3535

Atlanta, GA 30339

Office: 770-434-0042 or 770-884-8199

Fax: 888-501-4110

Authorization for Release of Information

Patient Name: _____ DOB: _____ Last 4 Digits of SSN: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Day Phone: _____ Email: _____

Reason for Disclosure: _____

I authorize the following facility/physician to release my records:

Name: _____

Address: _____

Please release the following items noted below from my medical record:

__Progress Notes __Radiology/Ultrasound Reports __Complete Medical Record

__Lab Results __Operative Report __Other: _____

Receiving Party & Method of Delivery: __ Mail (Complete info below) _Email (Please provide email above)
_Fax (required for continued care requests.)

Name: _____

Address: _____

_____

Fax #: _____ **necessary if going to another Doctor.

_____I understand that a fee for copying medical records may be incurred.

____I understand that this authorization will include any medical records including HIV records, psychiatric or alcohol abuse records and any other statutory protected disease unless otherwise stated so. This authorization and consent will expire 60 days following the date signed. I understand I may revoke this authorization at any time to the extent that action has previously taken in reliance hereof.
(Please check both to acknowledge.)

Date: Signature: _____