

**MEDICAL RECORD RELEASE**

Name of Provider or Practice or Facility: \_\_\_\_\_

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

City, State, Zip code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Purpose of this release:  Patient's continued health care  Other reason \_\_\_\_\_

I understand this authorization may be revoked at any time (revocation must be in writing) except for information that has already been released. Unless revoked, this authorization will expire six months from the date it was signed, or upon the following event or condition:

**Patient's full legal name:** \_\_\_\_\_

Other names used while under treatment: \_\_\_\_\_

Patient's date of birth: \_\_\_\_\_

Patient's address: \_\_\_\_\_

Patient's home telephone number: \_\_\_\_\_

Alternate telephone number: \_\_\_\_\_

I, \_\_\_\_\_

(Please Print)

Authorize the following medical records to be released to:

**North Atlanta Primary Care  
3400-C Old Milton Parkway, Suite 270, Alpharetta, GA, 30005  
Phone: 770-442-1911 Fax: 770-442-0306**

All treatment  Only for specified dates of: \_\_\_\_\_ through \_\_\_\_\_

Information to be released:

All records  Consultation reports  Discharge Summaries

Radiology reports  History and physical exam reports  Progress (office) notes

Laboratory reports  Other: (Describe) \_\_\_\_\_

I understand and specifically request that these records will include information about (check those desired)

AIDS/HIV Infection  Psychiatric/Behavioral health care  Treatment for drug or alcohol abuse

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Signature of patient's legal representative (where required)

\_\_\_\_\_  
Date signed