NORTH ATLANTA PRIMARY CARE

Medical Records Release Form

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 of condition.

RELEASE FROM:

NAME OF PROVIDER/PRACTICE:_____

ADDRESS_____ SUITE #_____ CITY_____

STATE_____ ZIP_____ PHONE_____ FAX_____

PURPOSE OF THIS RELEASE _____PATIENT'S CONTINUED HEALTHCARE _____OTHER:_____

PATIENT INFORMATION:

FULL LEGAL NAME_____ DATE OF BIRTH_____

OTHER NAMES USED FOR TREATMENT_____

ADDRESS LINE 1_____ ADDRESS LINE 2_____

CITY_____ STATE_____ ZIP_____

(HOME) PHONE_____(CELL) PHONE_____ (WORK) PHONE_____

I, _____AUTHORIZE THE FOLLOWING MEDICAL RECORDS TO
(PLEASE PRINT NAME)

BE RELEASED TO:

NORTH ATLANTA PRIMARY CARE

3400-C OLD MILTON PARKWAY, SUITE #270, ALPHARETTA, GA 30005

PHONE: (770) 442-1911 FAX: (770) 663-8905

INFORMATION TO BE RELEASED:

_____ALL RECORDS _____DISCHARGE SUMMARIES _____CONSULTATION REPORTS

_____RADIOLOGY REPORTS _____PROGRESS/OFFICE NOTES _____HISTORY & PHYSICAL EXAM REPORTS

_____LABORATORY REPORTS _____OTHER:_____

_____

_____RELEASE FOR SPECIFIED DATES ONLY: _____THROUGH_____

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

_____AIDS/HIV INFECTION _____PSYCHIATRIC/BEHAVIORAL HEALTHCARE _____TREATMENT FOR DRUG/ ALCOHOL ABUSE

_____ _____

PATIENT SIGNATURE DATE SIGNED

_____ _____

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE DATE SIGNED

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CITY_____ STATE_____ ZIP_____

(HOME) PHONE_____(CELL) PHONE_____ (WORK) PHONE_____

I, _____AUTHORIZE NORTH ATLANTA PRIMARY CARE TO RELEASE:
(PLEASE PRINT NAME)

_____RELEASE ALL INFORMATION _____RELEASE ONLY FOR SPECIFIED DATES: _____THROUGH_____

INFORMATION TO BE RELEASED:

_____ALL RECORDS _____DISCHARGE SUMMARIES _____CONSULTATION REPORTS

_____RADIOLOGY REPORTS _____PROGRESS/OFFICE NOTES _____HISTORY & PHYSICAL EXAM REPORTS

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ADDRESS_____ SUITE #_____ CITY_____

STATE_____ ZIP_____ PHONE_____ FAX_____

PURPOSE OF THIS RELEASE _____PATIENT'S CONTINUED HEALTHCARE _____OTHER:_____

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PATIENT SIGNATURE DATE SIGNED

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SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE DATE SIGNED