Medical Records Release

Name of Provider/Practice/Facility: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ Fax: _____

Purpose of this release: ____ Patient's continued healthcare 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 information ____ Only for specified dates _____ through _____

Information to be released:

___ All records ____ Consultation reports ____ Discharge Summaries

___ Radiology Reports ____ History & 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 healthcare ___ Treatment for drug/alcohol abuse

_____ _____
Patient Signature Date Signed

_____ _____
Signature of Patient's legal representative (when required) Date Signed