Peachtree Primary Care, PC

1570 Old Alabama Rd, Suite 105 Roswell, Georgia 30076
Telephone: 770-676-6838 Fax: 770-676-6840

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form

Patient's Name_____ Birth Date_____
(Please Print) LAST FIRST MI

TYPE OF MEDICAL INFORMATION REQUESTED:

- □ Complete medical records (includes 3 years of chart notes, most recent labs/ pathology & diagnostic imaging reports)
- □ Cancer Partnership
- □ Echocardiograms
- □ Pharmacy
- □ Behavioral Health records only
- □ Other: _____

REASON FOR REQUEST: Personal, Transfer of Care, Disability, Insurance, Legal Review, Continuing Care

□ Other (please explain): _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services and treatment for alcohol and drug abuse. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

_____

I hereby consent to release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent.

1.) Physicians/ Practice Name: _____

Tel: _____ Fax: _____

2.) Physicians / Practice Name: _____

Tel: _____ Fax: _____

3.) Physicians/ Practice Name: _____

Tel: _____ Fax: _____

Please fax records to: (770) 676-6840

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____