

North Chattahoochee

FAMILY PHYSICIANS, LLC.

11459 Johns Creek Parkway
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(770) 497-1555

BOARD CERTIFIED FAMILY PHYSICIANS

H. Lonnie Gardiner, III M.D.
Scott D. Griffith, M.D.
Paul D. Ellis, M.D.
Douglas M. Radman, M.D.
Lisa L. Culpepper, M.D.

CERTIFIED FAMILY NURSE PRACTITIONERS

Kelly D. Caulley, FNP-BC
Kimberley Lowe, FNP-BC
Lauren Cordova, FNP-BC

CERTIFIED PHYSICIANS ASSISTANT

Donna McAllister, PA-C
Debra R. Elliott, PA-C
Bobby Treadwell Jr., PA-C

TO: _____

RE: Authorization for Release of Information

Medical Records Request for: _____

Date of Birth: _____

I, _____, authorize _____ to release copies of my medical records for the period of _____ including:

- | | |
|---|---|
| <input type="checkbox"/> History & Physical Exams | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Operation Report(s) | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> Other, Specify |

I understand that these records may contain psychiatric, drug, alcohol abuse, and/or infectious disease information. I want this information released to North Chattahoochee Family Physicians at the above address or **Fax to: 770- 497-9998**.

For the purpose of _____, I hereby release _____ from all legal liability that arises from the release of my medical records.

PATIENT'S SIGNATURE

DATE

Representative's Signature

Date

Relationship To Patient (Parent, Legal Guardian, Executor)

Witness Signature

Date

If the patient is a minor or is unable to sign his/her legally qualified representative may authorize the release of information.