North Chattahoochee
FAMILY PHYSICIANS, LLC.
11459 Johns Creek Parkway
Suite 250
Johns Creek, Georgia 30097
(770) 497-1555

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:

____History & Physical Exams
____Operation Report(s)
____Discharge Summary
____Complete Medical Records
_____Radiology Reports
_____Laboratory Reports
_____Pathology Reports
_____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.