Consent to Release Medical Records

1800 Northside Forsyth Dr. Suite 460 Cumming, GA 30041

Phone 770-888-8888 Fax 770-888-4502

Please transfer the medical records of: D.O.B:

_____

_____

_____

Requesting records from:

Practice/Physician Name: _____

Address: _____

Phone #: _____

Fax #: _____

Reason for transferring records:

_____

The signature below serves as authorization to transfer records. I understand that these records may include psychiatric, chemical, substance abuse, HIV, and AIDS information. I understand that I may withdraw this authorization in writing at any time, except to the extent that action has been taken on this authorization.

****If the patient is under the age of 18 years old, my signature serves as authorization.

Authorized Signature _____

Print Name _____ Date _____