Medical Records Release

Name of Provider/Practice/Facility: ______________________________
Address: ______________________________
City, State, Zip Code: ______________________________
Telephone: ______________ Fax: ______________

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: ______________________________
Patient's date of birth: ______________________________
Patient's address: ______________________________
City, State, Zip Code: ______________________________
Patient's telephone number: ______________________________

Dunwoody Village Clinic
5471 Chamblee Dunwoody Road, Dunwoody, Ga 30338
Phone: 770-481-0889 Fax: 770-481-0986

___ All information ____ only for specified dates ______________ through ______________
Most recent records

Information to be released:
___ All records ____ Consultation reports ____ Discharge Summaries
___ Radiology Reports ____ History & Physical Exam Reports ____ Progress/Office Notes
___ Laboratory Reports ____ Other: (Describe) ______________________________

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. I understand that I might be billed by the copy service of their choosing for the charges incurred in processing my request and agree to pay any and all charges in full. Thank you.

______________________________ ______________

Patient Signature Date Signed