MEDICAL RECORDS RELEASE FORM

RELEASE RECORDS TO

I, _____ hereby consent and authorize the doctor and staff of Georgia Renew Clinic to release my medical records to _____. I understand that the specific amount of information disclosed may include a detailed report of my services.

PATIENT NAME:_____

ADDRESS:_____

CITY:_____ STATE_____ ZIP CODE:_____

DATE OF BIRTH:_____ PHONE NUMBER:_____

RECORDS REQUESTED FROM

I, _____ hereby consent and authorize the doctor and staff of _____ to release my medical records to Georgia Renew Clinic. I understand that the specific amount of information disclosed may include a detailed report of my diagnosis and services.

NAME OF DOCTOR/PHYSICILITY:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PHONE NUMBER:_____ FAX NUMBER:_____

Patient Signature:_____ DATE:_____
(if child, parent or legal guardian)