Innovation MD
2350 Limestone Pkwy,
Gainesville, GA 30501

Medical Record Request Form

Authorization To Release Confidential Health Information

PATIENT NAME: * _____

PATIENT DATE OF BIRTH * _____

Authorization for Use/Disclosure of Information:

I voluntarily consent to authorize my health care provider to use or disclose my health information during the term of this Authorization to the named recipient.

Purpose:

I authorize the release of my health information for the following specific purpose: *

- ☐ continuation of care
- ☐ transfer of care
- ☐ at the request of the patient

Information to be disclosed:

Date Range: * _____

All Healthcare Information: * ☐ Yes ☐ No

Treatment Summaries: * ☐ Yes ☐ No

Diagnostic Imaging Reports: *

- ☐ MRI
- ☐ CT
- ☐ EMG
- ☐ X-ray
- ☐ Others _____

Lab Results: * ☐ Yes ☐ No

I hereby authorize the above records to be leased FROM the office of:

DOCTOR'S NAME OR FACILITY NAME: * _____

ADDRESS: _____

Phone #: _____

To release my records TO:

Innovation MD
P. Tennent Slack, MD
Phone #: (470) 252-6710
Fax #: (877) 852-7990

Term:

Until 1 year from the date of the signed authorization or until I revoke this authorization.

PATIENT SIGNATURE: : _____

DATE: _____