CARTERSVILLE
URGENT CARE

MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____

I authorize the following custodian/entity to release the requested Medical Records.

Physician/Hospital: _____

Address: _____

Phone: _____

Fax: _____

Records should be released for the following dates: _____ to _____

Mark which of the following information is to be released.

All Records		Medical Records	
Lab/Pathology Reports		Progress Notes	
Radiology		Treatment Records	
Billing Records		Pharmacy/Prescription Records	
Care Plan		Operative Reports	
Hospital Records		Other (please list)	

If these records contain information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or STDs, you are hereby authorizing the disclosure of this information.

Please send the request records by mail or fax to the following location.

Physician/Hospital: _____

Address: _____

Phone: _____

Fax: _____

By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of the PHI listed above.

_____

(Patient's Signature or Guardian's If Minor) (Date)