

**MEDICAL RECORD RELEASE
North Atlanta Primary Care**

Phone: 770-442-1911 Fax: 678-802-5765

Patient's full legal name: _____

Other names used while under treatment: _____

Patient's date of birth: _____

Patient's address: _____

Patient's home telephone number: _____

Alternate telephone number: _____

I, _____

(Please Print)

Authorize **North Atlanta Primary Care**, to release my medical records for the following periods of treatment:

___ All treatment ___ Only for specified dates of: _____ through _____

Information to be released:

___ All records ___ Consultation reports ___ Discharge Summaries

___ Radiology reports ___ History and physical exam reports ___ Progress (office) notes

___ Laboratory reports ___ Other: (Describe) _____

I understand and specifically request that these records will include information about (check those desired)

___ AIDS/HIV Infection ___ Psychiatric/Behavioral health care ___ Treatment for drug or alcohol abuse

This information is to be released to:

Name of Provider or Practice or Facility: _____

Address: _____

City, State, Zip code: _____

Telephone: _____ Fax: _____

Purpose of this release: ___ Patient's continued health care Other reason _____

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:

I understand a fee of \$10.00 must be paid prior to the retrieval and mailing of my records.

Signature of patient Date signed

Signature of patient's legal representative (where required) Date signed

NAPC Physician's approval to release records Date signed

