MORROW
FAMILY MEDICINE

3970 Deputy Bill Cantrell Memorial Road
Suite 150 | Cumming, GA 30040
T: 770.781.8004 F: 678.679.4053

PLEASE FAX THIS FORM TO THE RELEASING PRACTICE

MEDICAL RECORD RELEASE

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:

Specify event/condition here:_____

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 the following medical records to be released to:

Morrow Family Medicine
3970 Deputy Bill Cantrell Memorial Road, Suite 150,
Cumming, GA 30040
Phone 770.781.8004 Fax 678.679.4053

◯ 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

_____ _____
Signature of patient Date signed

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