North Fulton Internal Medicine Group, P.C.

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Practice Manager

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Chief Administrative Officer

Medical Records Release Request

I hereby request and authorize_____ to release information from the medical record of:

PATIENT NAME_____

SS#: _____ **DOB:** _____

Information requested to be released: _____

From: _____

_____

_____

To: **North Fulton Internal Medicine Group**

2500 Hospital Blvd., Ste. 250, Roswell, GA 30076

Phone #: (770)442-1111 Fax #: (770)740-2990

The reason for releasing this information: **PCP/ continuation of care**

I place no limitations on the medical information released including conditions related to the treatment or mention of alcohol or drug abuse, HIV/AIDS, or psychiatric disorders. I release NFIMG and its employees from any responsibility or liability for the release of medical information.

_____

Patient Signature **Date**