AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____

Patient's Name

_____

Patient's Address

_____

Date of Birth: _____

RECORDS REQUEST TO: **Practice/Physician Name: _____**

Address: _____

_____

Phone/Fax: _____ / _____

I hereby request and authorize the release of all medical records as indicated below, requested by **Renew Health Medical Center** (P: 770-822-3031)

_____ ALL medical records, including x-rays, radiology reports, treatment(s), procedures performed, diagnostic tests, and prognosis reports

_____ X-Rays Only

_____ MRI Only

_____ Other: _____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

_____ Please fax **or** mail records to:

Renew Health Medical Center
1550 Janmar Road, Suite B
Snellville, GA 30078-5779
FAX # 770-822-3032
# of Pages (including this cover) _____

Patient Signature _____ Date: _____

Witness to Signature: _____

PLEASE DO NOT FAX MEDICAL RECORDS IF OVER 25 PAGES!!!
PLEASE MAIL THEM. THANK YOU!