

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

I, \_\_\_\_\_, Authorize

Facility / Dr. \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

to release a complete copy of my records to:

Facility / Dr. MOUNTAIN PARK PRIMARY CARE CENTER  
Address 1755 EAST PARK PLACE BOULEVARD  
STONE MOUNTAIN, GEORGIA 30087  
Telephone # (770) 469-2040 Fax # (770) 469-7010

I am aware that some health care information or other information contained in the requested medical records may be confidential or privileged, and hereby authorize my medical records to be released to the above named facility.

This authorization and consent is subject to revocation at any time except to the extent that the above person or organization has already taken action and released the records. If not previously revoked this authorization will terminate 90 days from the date that appears below.

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Title \_\_\_\_\_