MEDICAL RECORDS RELEASE AUTHORIZATION

ATTN: MEDICAL RECORDS

RE: _____ _____

Patient's Name | Patient's DOB

To: _____ _____

Doctor, Hospital, etc. | Fax#

I hereby authorize and request you to furnish medical records to:

FamilyCare
OF MIDDLE GEORGIA

3203 Vineville Ave
Macon, GA 31204
Office: 478-471-0273
Fax #: 478-471-1471

The medical record(s) in your possession, concerning illnesses and/or treatment during the period services were rendered to patient from _____ to _____.

I hereby release you from any legal responsibility or liability that may arise from releasing the foregoing information. A photocopy of the original of this document shall be treated as the same as the original and shall act as a release for the above information.

_____ _____

Signature of patient / guardian / power of attorney | Date

_____ _____

Printed Name of guardian or power of attorney | Relationship to Patient