SOUTHEAST MEDICAL GROUP

Medical Records Release Form

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 of condition.

RELEASE FROM:

NAME OF PROVIDER/PRACTICE:____________________

ADDRESS____________________ SUITE #__________ CITY____________________

STATE__________ ZIP__________ PHONE____________________ FAX____________________

PURPOSE OF THIS RELEASE _____PATIENT'S CONTINUED HEALTHCARE _____OTHER:____________________

PATIENT INFORMATION:

FULL LEGAL NAME____________________ DATE OF BIRTH____________________

OTHER NAMES USED FOR TREATMENT____________________

ADDRESS LINE 1____________________ ADDRESS LINE 2____________________

CITY____________________ STATE__________ ZIP____________________

(HOME) PHONE____________________(CELL) PHONE____________________ (WORK) PHONE____________________

I, ____________________AUTHORIZE THE FOLLOWING MEDICAL RECORDS TO
(PLEASE PRINT NAME)
BE RELEASED TO:

SOUTHEAST MEDICAL GROUP

New Address: 4300 Northpoint Parkway Suite 300; Alpharetta, Georgia, 30022

Phone: 770-442-1911 Fax: 770-663-8905 Email: medicalrecords@southeastmedicalgroup.com

INFORMATION TO BE RELEASED:

______ALL RECORDS ______DISCHARGE SUMMARIES ______CONSULTATION REPORTS

______RADIOLOGY REPORTS ______BILLING RECORDS ______HISTORY & PHYSICAL EXAM REPORTS

______LABORATORY REPORTS ______PROGRESS/OFFICE NOTES ______OTHER:____________________
____

______RELEASE FOR SPECIFIED DATES ONLY: ____________________THROUGH____________________

I understand and specifically request that these records will include information about (check those desired):

______AIDS/HIV INFECTION ______PSYCHIATRIC/BEHAVIORAL HEALTHCARE ______TREATMENT FOR DRUG/ ALCOHOL ABUSE

____
PATIENT SIGNATURE

____
DATE SIGNED

____
SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE

____
DATE SIGNED

SOUTHEAST MEDICAL GROUP

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RELEASE FROM:

SOUTHEAST MEDICAL GROUP

3400-C OLD MILTON PARKWAY, SUITE #270, ALPHARETTA, GA 30005

PHONE: (770) 442-1911 FAX: (770) 663-8905

PATIENT INFORMATION:

FULL LEGAL NAME____________________ DATE OF BIRTH____________

OTHER NAMES USED FOR TREATMENT____________________

ADDRESS LINE 1____________________ ADDRESS LINE 2____________

CITY______________ STATE________ ZIP______________

(HOME) PHONE__________(CELL) PHONE__________ (WORK) PHONE__________

I, ______________________AUTHORIZE SOUTHEAST MEDICAL GROUP TO RELEASE:
(PLEASE PRINT NAME)

______RELEASE ALL INFORMATION ______RELEASE ONLY FOR SPECIFIED DATES: ________THROUGH________

INFORMATION TO BE RELEASED:

______ALL RECORDS ______DISCHARGE SUMMARIES ______CONSULTATION REPORTS

______RADIOLOGY REPORTS ______PROGRESS/OFFICE NOTES ______HISTORY & PHYSICAL EXAM REPORTS

______LABORATORY REPORTS ______OTHER:____________________
____

______RELEASE FOR SPECIFIED DATES ONLY: ______________THROUGH______________

I understand and specifically request that these records will include information about (check those desired):

______AIDS/HIV INFECTION ______PSYCHIATRIC/BEHAVIORAL HEALTHCARE ______TREATMENT FOR DRUG/ ALCOHOL ABUSE

RELEASE TO:

NAME OF PROVIDER/PRACTICE:____________________

ADDRESS____________________ SUITE #________ CITY______________

STATE________ ZIP__________ PHONE______________ FAX______________

PURPOSE OF THIS RELEASE _____PATIENT'S CONTINUED HEALTHCARE _____OTHER:______________

____________________ ____________
PATIENT SIGNATURE DATE SIGNED

____________________ ____________
SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE DATE SIGNED