

Authorization for Release of Information

PATIENT NAME	DATE OF BIRTH
PATIENT ADDRESS	
	uthorize the release and/or disclosure of my medical records and
diagnostic tests results to Personalized Primary Care	in compliance with the manner defined below.
□ All dates of service □ Only the specified date	(s) of service:
□ Records of care concerning the following conditi	ion(s):
Other, Specify:	
RECORDS TO BE RELEASED TO/FROM	
Healthcare Provider(s):	Healthcare Provider(s):
Facility:	Facility:
City/State:	
Phone: Fax:	Phone: Fax:
Other:	Other:
Please Include:	
By initialing, I am also giving my permission Primary Care about information pertaining to my me	n for the entities listed above to confer orally with Personalized dical record.
PLEASE FORWARD MEDICAL RECORDS TO	O:
Personalized Primary Care	
57 Executive Park South, Suite 390	
Atlanta, GA 30329	
Phone: (404) 997-6790	
Facsimile: (404) 997-6791	
Signature of Patient or Guardian	Date
	 Date