Medical Record Authorization Form

Name: ________________________________

Date of Birth: ___________________________

Consent: I aforementioned above, hereby authorize: Urgent Care at Druid Hills, 2882 N. Druid Hills Rd. NE Ste. B, Atlanta, GA 30329 to release copies of my medical records to myself, and if I so choose a third party and/or another medical provider of my choice which will be listed below if needed.

Records Needed:

All Records: ☐ Medical Notes: ☐ Labs: ☐ Itemized Bi ☐

Other: ____

Special Instructions: ____

Send Records to:

Name of Person or Facility: ____

Fax: ☐ Fax Number: ____

Email: ☐ Email Address:

____

Mail: ☐ Mailing Address: ____

I understand this authorization is valid until a written revocation has been provided to Urgent Care at Peachtree requesting records to no longer be sent to parties aforementioned above. I understand a photocopy of this document is as valid as the original.

Signature: ____ Date: _______________________

Guardian Signature: ________________________________ Date: _______________________

Guardian Printed Name: ____