Medical Record Authorization Form

Name: _____

Date of Birth: _____

Consent: I aforementioned above, hereby authorize: Urgent Care at Peachtree, 2140 Peachtree RD. Suite 232 Atlanta, GA 30309 to release copies of my medical records to myself, a third party, and/or another medical provider of my choice.

Records Needed:

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

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: _____

For your protection, please attach a photocopy of your ID with this form.