Name: ________________________________
DOB: ______________________
Address: ________________________________
City: ________________ State: ______ Zip: ________

Where Are We Sending the Records?

Name: ____________________________
Address: ____________________________
Phone: __________________ Fax: ______________

What would you like released?

___ All Records
___ Radiology Reports
___ Office/Clinic Notes
___ Imaging CD
___ Operative Reports
___ Other

If you do not want certain portions of your medical records released, please check the categories listed below you would like to exclude.

___ Substance Abuse
___ AIDS/HIV/STD
___ Psychological/Psychiatric Conditions

Why are we sending the records?

_____ Personal Use ____ Litigations/Legal ___ Insurance ___ Transfer of Care

Delivery Method?

___Fax ___ Mail ___ Pick-Up

I hereby authorize Georgia Spine & Orthopedics LLC to release or disclose to the person(s) or organization listed above, all medical records requested, including any specialty protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIVE infection, unless otherwise noted. This authorization is valid for 12 months for the date of signature. I understand that I may cancel my request with written notification but that it will not affect any information released prior to the notification cancellation.

____

PATIENT SIGNATURE/DATE