PPC Personalized Primary Care
General Internal Medicine

Authorization for Release of Information

PATIENT NAME _____ **DATE OF BIRTH** _____

PATIENT ADDRESS _____

I, _____, do hereby authorize 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 condition(s):**_____
_____
□ **Other, Specify:** _____

RECORDS TO BE RELEASED TO/FROM

Healthcare Provider(s): _____
Facility: _____
City/State: _____
Phone: _____ Fax: _____
Other: _____

Healthcare Provider(s): _____
Facility: _____
City/State: _____
Phone: _____ Fax: _____
Other: _____

Please Include: _____
_____
_____

_____ By initialing, I am also giving my permission for the entities listed above to confer orally with **Personalized Primary Care** about information pertaining to my medical record.

PLEASE FORWARD MEDICAL RECORDS TO:
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

_____ _____
Witness Date