



## Medical Record Authorization Form

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Consent: I aforementioned above, hereby authorize: Urgent Care at Peachtree, 2140 Peachtree Rd. NW Ste. 232, Atlanta, GA 30309 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 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: \_\_\_\_\_