

# MEDICAL RECORDS RELEASE REQUEST

## **Cobb Internal Medicine Associates, P.C.**

Seema Hisamud-Din, M.D.

Mohsin Hisamud-Din, M.D.

Gina Taylor, NP

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

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

Address: \_\_\_\_\_

### **Please release my Medical Records from:**

Name of Provider: \_\_\_\_\_

Providers Fax/Phone: \_\_\_\_\_

Address: \_\_\_\_\_

To: **Cobb Internal Medicine**  
2655 Dallas Hwy, Ste 340  
Marietta GA, 30064

Phone : 678-797-9800  
**Fax: 678-797-9801**

### **PLEASE DO NOT SEND ALL RECORDS UNLESS SPECIFIED BELOW**

- PROBLEM LIST/MEDICATION LIST
- LAST 2 OFFICE VISITS
- LABS/XRAYS
- IMMUNIZATIONS
- ALL RECORDS**

I understand this authorization includes release of medical records including HIV records, Psychiatric, Mental illness, Drug/Alcohol abuse records, Venereal Disease and other statutory protected diseases. This authorization and consent will expire ninety days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that the action has previously taken in reliance hereof.

I hereby authorize the release of my medical records as provided above:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature : \_\_\_\_\_ Void Date: \_\_\_\_\_