MEDICAL RECORDS RELEASE REQUEST

Cobb Internal Medicine Associates, P.C.

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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

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

I understand this authorization includes release of medical records including HIV records, Psychiatric, Mental illness, Drug/Alchol 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: _____