

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

- ☐ 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: _____