SANDY SPRINGS
SSIM
INTERNAL MEDICINE

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I hereby request and authorize _____ to release information from the medical record of:

PATIENT NAME:

DATE OF BIRTH:

ACCOUNT NUMBER:

Information requested to be released: MEDICAL RECORDS

From: _____

_____

_____

To: Sandy Springs Internal Medicine, P.C.

755 Mount Vernon Hwy., Ste. 500

Atlanta, GA 30328

The reason for releasing this information PRIMARY CARE PHYSICIAN

I hereby give permission to release the information requested on this form including release of information relating to: psychiatric records, psychotherapy notes, alcohol and/or drug abuse records; HIV/AIDS information; genetic testing, and/or sexually transmitted disease information (if applicable) to the individual/agency listed above and only for the purposes I have indicated. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing.

_____ _____

Patient signature Date

Please list below any physicians to obtain medical records from: (Sign form on reverse)