



North Fulton Internal Medicine Group, P.C.

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Medical Records Release Request

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

Patient Name: _____

DOB: _____ SSN: _____

Information requested to be released: _____

From: _____

To: _____

The reason for releasing this information: _____

I place no limitations on the medical information release including conditions related to the treatment or mention of alcohol or drug abuse, HIV/AIDS, or psychiatric disorders. I release NFIMG and its employees from any responsibility or liability for the release of medical information.

Patient Signature

Date