Fill out the following form, then click the 'Save Form' button to save the form to your computer. If using Google Chrome, right-click the form and select 'Save As...' Send the form in an email to the following address: medicalrecords@ganephrology.com.

Consent for Release of Medical Records

Name of Patient: _____ Date of Birth: _____

The patient above is requesting a copy of his/her records to be sent to:

Name of Doctor/Hospital/Facility: Georgia Nephrology-Medical Records Department
Address: 595 Hurricane Shoals Road NW, Suite 100, Lawrenceville. GA 30046
Fax: 678.990.5259

I, _____am authorizing my medical records to be released to the above-mentioned Doctor/Hospital/Facility.

I do hereby consent and authorize the office to release copies of my medical records, including current and previous medical records to other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for release of alcohol, drug, psychiatric and psychological information and any other information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and AIDS-related syndromes. I agree that a copy of this release or fax of this release shall be as valid as the original release. Please send copy of all required information as soon as possible via fax or to the address listed above.

Patient's Signature: _____ Date: _____

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