CENTRAL GEORGIA
HEART & VEIN CENTER

MEDICAL RECORDS RELEASE FORM_

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Records being requested from:

Dr. _____ Phone Number: _____ Fax Number: _____

Dr. _____ Phone Number: _____ Fax Number: _____

Dr. _____ Phone Number: _____ Fax Number: _____

Dr. _____ Phone Number: _____ Fax Number: _____

The information you may release subject to this signed release form is as follows:

◯ Complete Records (last 2 years)

◯ Lab Reports

◯ Pathology Reports

◯ Progress Notes

◯ Radiology Report

◯ Immunization Records

◯ H&P

◯ Rx Records

◯ Hospital Reports

◯ Other (Please specify below)

_____

_____

_____

Release my protected health information to the following physician/facility:

Central Georgia Heart and Vein Center

1062 Forsyth Street Suite 1B

Macon, Ga 31201

Phone: 478-741-1208

Fax: 478-743-4193 / 478-238-6192

Signature: _____