

PRIMARY CARE PHYSICIANS OF ATLANTA, P.C.

INTERNAL MEDICINE
5670 PEACHTREE DUNWOODY ROAD, N.E.
SUITE 1200
ATLANTA, GEORGIA 30342
(404) 255-9100

FAX (404) 257-7171
WWW.PCPATL.COM

LONNIE HERZOG, M.D., F.A.C.P.
DAVID A. SMITH, M.D.
SAMUEL F. ADAMS, M.D.

ROBERT A. DIEKROEGER, M.D.
SANDRA K. BANKS, M.D.
RUSSELL C. MAXA, M.D.

SCOTT J. SMALL, M.D.
THOMAS L. WEEKS, III, M.D.
AMY L. VARNER, M.D.

MEDICAL RECORD RELEASE FORM

TO:

I, _____, REQUEST THAT YOU RELEASE MY MEDICAL RECORDS (INCLUDING X-RAYS AND REPORTS) TO:

PRIMARY CARE PHYSICIANS OF ATLANTA, P.C.

- LONNIE HERZOG, M.D., F.A.C.P.
- DAVID A. SMITH, M.D.
- SAMUEL F. ADAMS, M.D.
- ROBERT A. DIEKROEGER, M.D.
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I UNDERSTAND THIS AUTHORIZATION INCLUDES RELEASE OF ALL MEDICAL RECORDS, INCLUDING BUT NOT LIMITED TO INFORMATION RELATED TO PSYCHIATRIC CARE, DRUG, TOBACCO, ALCOHOL OR OTHER SUBSTANCE ABUSE, GENETIC TESTING, HIV/AIDS OR OTHER SEXUALLY-TRANSMITTED DISEASES, AND ANY OTHER STATUTORY-PROTECTED CONDITION AND/OR TREATMENT PROVIDED.

THIS AUTHORIZATION AND CONSENT WILL EXPIRE NINETY (90) DAYS FOLLOWING THE DATE SIGNED.

PATIENT NAME: _____

SIGNATURE _____ DATE _____

SSN _____ DOB _____