



MED GLOBE, P.C.

PRIMARY CARE/ INTERNAL MEDICINE

Authorization for Release of Medical Records

I authorize the following protected health information to be released from the medical record of

Last Name	First Name	D.O.B
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Address	City	State	Zip
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Phone Number	Date
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Release Records

- From Med Globe, P.C.
- To 1686 Roswell Road
Marietta, GA 30062
Phone: 770 933 9333
Fax: 770 579 9331

Release Records

- From _____
- To Physician's/Organization's Name

Address

City State Zip

Phone Fax

Please Send to Med Globe, P.C. via Mail Please Call When Ready for Pick Up Please Fax to Med Globe

I understand that to the extent any recipient of this information, as identified above, is not a "Covered Entity" under Federal or Georgia privacy law, the information may no longer be protected by Federal and Georgia privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

To Be Released

- | | | |
|---|---|--|
| <input type="checkbox"/> Office Visits and Labs | <input type="checkbox"/> Immunization | <input type="checkbox"/> Gyn Visits And Labs |
| <input type="checkbox"/> Physical Therapy Notes | <input type="checkbox"/> Urgent Care Visits | <input type="checkbox"/> Nurse Advice Line |
| <input type="checkbox"/> Lab Work | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Entire Record |

Signature of Patient or Legal Representative	Date
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