



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