North Fulton Internal Medicine Group, P.C.

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Sandy Gilliard
Practice Manager

Charity Q. Boulton, C.M.P.E.
Chief Administrative Officer

Medical Records Release Request

I hereby request and authorize the release of 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