



Office 912-283-1359 Fax 912-283-1360

RECORDS RELEASE

Patient Name _____ Provider: _____

Date of Birth _____ Telephone: _____

Address _____ City/State/Zip _____

I authorize Elite Medical Group to release or obtain my medical information. I also give Elite Medical Group permission to speak with any physician at any time in reference to me or my medical condition.

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Release Records TO and or FROM: (circle appropriate selection)

Records needed by the following date: _____

Medical Records Requested (ex. Labs, Xray, etc.)

Phone: _____ Fax: _____

Address: _____

City/State/Zip _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Elite Medical Group. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the term and conditions of this authorization.

Signature of Patient/Authorized Rep

Date

Witness Signature

Date