S O U T H F O R S Y T H F A M I L Y M E D I C I N E A N D
P E D I A T R I C S
1845 Lockeway Drive, Suite 404
Alpharetta, Georgia 30004
Phone: 770-343-9112
Fax: 770-343-8911

David S. Boaz, M.D. Mark Glodener, M.D. Giouzel Glodener, M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize:

_____

_____

_____

to release medical records to (Name of Facility/Provider):

South Forsyth Family Medicine and Pediatrics
1845 Lockeway Drive
Alpharetta GA 30004

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ Zip Code: _____

Home Phone#: _____ Alternate #: _____

I understand that this information is voluntary. I understand that the information in my health records may include information related to genetic testing, HIV, behavior or mental health, alcohol or drug dependency. I understand that I may withdraw this consent at any time by writing to provider. This authorization will expire in 6 months. The purpose of this information is to provide continuing medical care.

Description of information to be released:

____ Medical Records from the following dates: _____

____ Entire Medical Record	____ Radiology/Imagine studies
____ Growth Charts	____ Consultations
____ Immunization Records	____ Problem List
____ Laboratory Testing	____ Other: _____

Fax Information: _____ Mail Information: _____ Patient Pick-up: _____

SIGNATURE OF PATIENT/GUARDIAN: _____

Relationship if not Patient: _____ Date: _____