Georgia Mountain Dermatology, LLC

Medical Records Release Authorization

Patient Name: ______________________________ **Date of Birth:** ___________

I hereby authorize the release of the following medical information:

☐ **FROM** ☐ **TO**

Georgia Mountain Dermatology, LLC
150 Interstate South Dr, Suite 100
Jasper, GA 30143

Phone (706) 253-3376 Fax (706) 253-3223

☐ **FROM** ☐ **TO**

Practice or Provider Name: _____________________________
Address: _______________________________
____
____
Phone: ________________ **Fax:** __________________________

Please send:

☐ All medical records ☐ Lab Reports

☐ Pathology Reports ☐ Other: ____________________

I understand that I may revoke this authorization at any time by sending a written request. I also understand that if I revoke this authorization, the revocation will not be effective for information already disclosed, based on this authorization. If I do not sign this authorization, Georgia Mountain Dermatology, LLC will not release any medical records to the requested medical office.

Signature: ______________________________ **Date:** ____________________