AUTHORIZATION FOR DISCLOSURE/RELEASE OF MEDICAL INFORMATION

Patient Information:

_____

Name (Last, First) Social Security Number

_____

Address City State Zip

____/____/_____ _____ _____

Date of Birth Home Phone Number Cell or Work Number

Medical Records From:

_____

Name of Organization and/or Name of Physician

_____

Address City State Zip

_____ _____

Office Phone Number Office Fax Number

Please release the following information:

0 Complete Medical Records **0 Consultation Reports**

0 Mammogram Reports **0 Ultrasound / Radiology Reports**

0 Laboratory Records **0 Pathology Reports**

0 Progress / Office Visit Notes **0 Other - _____**

Reason For Release: _____

I am aware that some of the information in my medical records may be of a sensitive nature. By signing this release, I am granting permission for information pertaining to the above mentioned areas to be released. I waive any privilege of confidentiality existing under Federal or State law regarding such information. This Authorization and Consent will expire in 30 days from the authorized date.

_____

Signature of Patient or Representative **Date**

_____

Mail or Fax Information To:

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Michael F. Perry, M.D., FACOG
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ATLANTA, GA 30306
Office 404.685.8867 - Fax 404.685.8137