



## Medical Records Release

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize: PEACHTREE IMMEDIATE CARE

to release my medical records to \_\_\_\_\_

at (Fax #) \_\_\_\_\_

Please Send:

- All Records
- From \_\_\_\_\_ to \_\_\_\_\_ date(s) of service
- Other \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

For the following information for any of our locations: Address, Fax or Phone Numbers, Please visit our website at [www.peachtreemed.com](http://www.peachtreemed.com).