PRIMARY CARE PHYSICIANS OF ATLANTA, P.C.
INTERNAL MEDICINE
5670 PEACHTREE DUNWOODY ROAD, N.E.
SUITE 1200
ATLANTA, GEORGIA 30342
(404) 255-9100
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MEDICAL RECORD RELEASE FORM

TO:

I, _____, REQUEST THAT YOU RELEASE MY MEDICAL RECORDS (INCLUDING X-RAYS AND REPORTS) TO:

PRIMARY CARE PHYSICIANS OF ATLANTA, P.C.

- ❑ LONNIE HERZOG, M.D., F.A.C.P.
- ❑ DAVID A. SMITH, M.D.
- ❑ SAMUEL F. ADAMS, M.D.
- ❑ SANDRA K. BANKS, M.D.
- ❑ RUSSELL C. MAXA, M.D.
- ❑ SCOTT J. SMALL, M.D.
- ❑ THOMAS L. WEEKS III, M.D.
- ❑ NGOC DIEM ANKE DOAN, M.D.
- ❑ CESAR M. CESTERO, M.D.
- ❑ ALEXANDER M. HERZOG, M.D.
- ❑ MAX E. GREEN, M.D.

5670 PEACHTREE DUNWOODY RD., N.E., SUITE 1200
ATLANTA, GA 30342

I UNDERSTAND THIS AUTHORIZATION INCLUDES RELEASE OF ALL MEDICAL RECORDS, INCLUDING BUT NOT LIMITED TO INFORMATION RELATED TO PSYCHIATRIC CARE, DRUG, TOBACCO, ALCOHOL OR OTHER SUBSTANCE ABUSE, GENETIC TESTING, HIV/AIDS OR OTHER SEXUALLY–TRANSMITTED DISEASES, AND ANY OTHER STATUTORY- PROTECTED CONDITION AND/OR TREATMENT PROVIDED.

THIS AUTHORIZATION AND CONSENT WILL EXPIRE NINETY (90) DAYS FOLLOWING THE DATE SIGNED.

PATIENT NAME:_____

SIGNATURE_____DATE_____

SSN_____DOB_____