PRIMARY CARE PHYSICIANS OF ATLANTA, P.C.
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RUSSELL C. MAXA, M.D.
SCOTT J. SMALL, M.D.

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.
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ATLANTA, GA 30342

I UNDERSTAND THIS AUTHORIZATION INCLUDES RELEASE OF ALL MEDICAL RECORDS, INCLUDING HIV, PSYCHIATRIC MENTAL ILLNESS, DRUG/ALCOHOL ABUSE, VENEREAL DISEASE, GENETIC TESTING, AND ANY OTHER STATUTORY PROTECTED DISEASE. THIS AUTHORIZATION AND CONSENT WILL EXPIRE NINETY (90) DAYS FOLLOWING THE DATE SIGNED.

PATIENT NAME:_____

SIGNATURE_____DATE_____

SSN_____DOB_____