

# Medical Records Release Authorization

I, \_\_\_\_\_, \_\_\_\_\_  
NAME (Please Print) STREET ADDRESS  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
CITY STATE ZIP DATE OF BIRTH

authorize the release of medical records from the following physician(s):

Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

## PLEASE SEND RECORDS TO:

Michael D. Randell., M.D., F.A.C.O.G.  
980 Johnson Ferry Road • Suite 230  
Atlanta, Georgia 30342  
Phone: 404-250-4443  
Fax: 404-250-4423

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date