Northcrest Family Medicine
7768 Cumming Hwy, Ste 300
Canton, GA 30114
770-720-2113
770-704-7365 fax

REQUEST FOR RECORDS RELEASE

Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone # _____ Fax # _____

The following individual has asked that his/her medical records be released and forwarded to our office:

Patient Name: _____

Birth Date: _____ Social Security Number: _____

Please be sure to include X-ray films and reports.

Thank you for expediting this request. Please send these records to our office address shown above.

Patient Authorization

I hereby authorize the release of all my medical records to Northcrest Family Medicine

please forward them as soon as possible.

Patient's Signature: _____ Date_____
(Parent or guardian if patient is a minor)

Patient's Address: _____

City: _____ State: _____ Zip: _____