



North Fulton Internal Medicine Group, P.C.

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Medical Records Release Request

I hereby request and authorize _____ to release information from the medical record of:

PATIENT NAME _____

SS#: _____ DOB: _____

Information requested to be released: _____

From: _____

To: North Fulton Internal Medicine Group
2500 Hospital Blvd., Ste. 250, Roswell, GA 30076
Phone #: (770)442-1111 Fax #: (770)740-2990

The reason for releasing this information: PCP/ continuation of care

I place no limitations on the medical information released including conditions related to the treatment or mention of alcohol or drug abuse, HIV/AIDS, or psychiatric disorders. I release NFIMG and its employees from any responsibility or liability for the release of medical information.

Patient Signature

Date