



**FAMILY PRACTICE, PEDIATRICS, BEHAVIORAL HEALTH, CHIROPRACTIC,  
OPTOMETRY & DENTAL SERVICES**

**Medical Records Release**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Information to be used or disclosed must be identified in a specific and meaningful fashion (see checklist below). The purpose of the use and disclosure is to provide medical treatment and services. I hereby request copies of all records pertaining to my health history and medical care released to:

**EAST GEORGIA HEALTHCARE CENTER  
215 NORTH COLEMAN STREET, SWAINSBORO, GA 30401  
478-237-2638 PH 478-237-9138 FAX**

Requesting medical records from: \_\_\_\_\_

**PLEASE INCLUDE ALL INFORMATION CHECKED:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> All Medical Records, Including Psychiatric | <input type="checkbox"/> HIV Records          | <input type="checkbox"/> Pap Reports         |
| <input type="checkbox"/> All Medical Records, Except Psychiatric    | <input type="checkbox"/> Hospital Records     | <input type="checkbox"/> Progress Notes      |
| <input type="checkbox"/> Colonoscopy Reports                        | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Psychiatric Records |
| <input type="checkbox"/> Current Medications                        | <input type="checkbox"/> Laboratory Data      | <input type="checkbox"/> X-ray Reports       |
| <input type="checkbox"/> Drug and Alcohol Tests                     | <input type="checkbox"/> List of Allergies    | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> EKG Reports                                | <input type="checkbox"/> Mammogram Results    |  |

**NO DISC – Please mail**

One time release \_\_\_\_\_

Coordination of Care (as long as patient is under the care of both providers) \_\_\_\_\_

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Patient Signature or Personal Representative

\_\_\_\_\_  
Date

As a personal representative, I have authority to act for the individual because I am: \_\_\_\_\_