West Atlanta Primary care

Medical Record Release

Date _____

Full Name _____ Date of Birth _____

I Authorize the release of my medical records from

1_____
(Name of the Physician and Medical practice)

_____
(Street) (City/State) (Zipcode)

_____
(Phone#) (Fax#)

2_____
(Name of the Physician and Medical practice)

_____
(Street) (City/State) (Zipcode)

_____
(Phone#) (Fax#)

3_____
(Name of the Physician and Medical practice)

_____
(Street) (City/State) (Zip code)

_____
(Phone#) (Fax#)

_____
(Signature)

Please fax or mail Medical Records to:

West Atlanta Primary care
4904 Timber Ridge Drive, Suite 102
Douglasville, GA 30135
PH: 678- 401- 4597 FAX: 1-8884984621