Oconee Family Practice, PC

REQUEST FOR RECORDS FROM ANOTHER DOCTOR OR FACILITY

Patient Name:	Date of Birth:	SSN:

Please release my medical records to Oconee Family Practice **from** the following:

Doctor/Facility:	Street address:	
City:	State:	ZIP:
Phone:	FAX:	

PURPOSE OF RELEASE

☐ **Copy of Record** ☐ **Continuity of Care** ☐ **Legal or Insurance**

Other (please specify) _____

INFORMATION TO BE RELEASED:

☐ **All records** ☐ **Test Results** ☐ **Most recent visit**

Other (please specify) _____

I understand this medcal record may contain information about drug abuse, alcoholism, alcohol abuse, sexcually transmitted diseases, abortion, or mental health treatment. Additionally, this medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment.

RELEASE TO: Oconee Family Practice, PC
1747 Langford Dr, Bldg 400-105
Watkinsville, GA 30677

FAX (706) 310-9847
(706) 769-1100

PATIENT'S RIGHTS AND SIGNATURE:

I understand that

- I have the right to withdraw this consent at any time except where information has already been released.
- I do not have to sign this authorization to receive treatment.
- This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.

_____ _____

Signature of Patient (or parent/guardian if minor) Date