

Savitha Shama M.D.

Internal Medicine

P: 678.827.9157 **F: 470.299.6262**

**Authorization to Release Medical Records**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name |  | SSN |  |
| Dates of Service |  | Date of Birth |  |

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| History & Physical |  | Consultation Reports |  | Emergency Room Record |  |
| Operative Reports |  | Discharge Summary |  | Face Sheet |  |
| Lab/Path Reports |  | X-Ray Reports/Images |  | Other: |  |

Please release the above information to:

Milton Medical Group

Dr. Savitha Shama

735 N Main ST STE 1100

Alpharetta, GA 30009

PH: 678-827-9157

Fax: 470-299-6262

**FROM:** ***(Please enter information of provider from where we need to obtain your medical records)***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Provider Name |  | | | | |
| Street Address |  | | | | |
| City |  | State |  | ZIP |  |
| Phone |  | | Fax |  | |

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Signature: |  |
| Print Name of Patient or Legally Authorized Representative: | | | |

735 N. Main St, Suite 1100, Alpharetta, GA 30009