Medical Records Release Form

Release from:

Cardiology of South Forsyth, P.C.
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Cumming, Georgia 30041
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PATIENT INFORMATION:

FULL LEGAL NAME_____

DATE OF BIRTH_____

ADDRESS_____

CITY_____STATE_____ZIP_____

(HOME) PHONE_____ (CELL) PHONE_____

I, _____ AUTHORIZE CARDIOLOGY OF SOUTH FORSYTH, P.C.
(please print name)

TO RELEASE MY CARDIOLOGY RECORDS TO:

NAME OF PROVIDER/PRACTICE:_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE_____FAX_____

PURPOSE OF THIS RELEASE IS FOR CONTINUITY OF CARE OR _____

_____ _____
PATIENT SIGNATURE DATE SIGNED

I understand this authorization may be revoked at any time (revocation must be in writing) except for information that has already been released. Unless revoked, this authorization will expire six months from the date it was signed.

In order to avoid a fee please fax or mail this form prior to August 24, 2022