Piedmont Radiology

RADIOLOGY ASSOCIATES OF ATLANTA

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print):

Name _____ Date of Birth _____

SSN _____ Phone _____

Address _____

City _____ State _____ Zip code _____

RELEASE MY MEDICAL RECORDS TO:

_____, MD _____

Piedmont Radiology
Phone: 404-352-1409
Fax: 404-352-8176

I AUTHORIZE PIEDMONT RADIOLOGY TO RELEASE RECORDS TO:

_____

_____

_____

_____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS

Patient _____ Date _____