

ATLANTA NEUROLOGICAL ASSOCIATES, P.C.

1288A WELLBROOK CIRCLE
CONYERS, GA 30012
PH: 770-929-0777 FAX: 770-929-3107

TO: _____

PLEASE RELEASE THE MEDICAL RECORDS ON THE FOLLOWING:

NAME: _____

PREVIOUS NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____

RECORDS REQUESTED:

_____ Hospital (H&P, Discharge Summary, Radiology, Test Results, Labs)

_____ Complete Medical Records

I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

CIRCLE REQUESTING PHYSICIAN NAME:

WILLIAM BIKOFF

ROBERT SCHNAPPER

MARSHA SMITH

Signature of Patient/Guardian

Date of Signature

Relationship to Patient

Signature of Witness