

**ATLANTA NEUROLOGICAL ASSOCIATES, P.C.**  
**1277A WELLBROOK CIRCLE**  
**CONYERS, GEORGIA 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.**

**REQUESTING PHYSICIAN:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient/Guardian**

\_\_\_\_\_  
**Date of Signature**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Signature of Witness**