PPC Personalized Primary Care
General Internal Medicine

Medical Records Release

Name:_____

Date of Birth:_____

I authorize the release of my medical records from:

(Name of Physician or Medical Practice #1)

(Street Address (City/State) (Zip Code)

(Phone #) (Fax#)

(Name of Physician or Medical Practice #2)

(Street Address (City/State) (Zip Code)

(Phone #) (Fax#)

(Name of Physician or Medical Practice #3)

(Street Address (City/State) (Zip Code)

(Phone #) (Fax#)

Please send copies of my medical records to:

Personalized Primary Care, LLC
57 Executive Park South, Suite 390
Atlanta, GA 30329
Telephone: 404-997-6790
Fax: 404-997-6791

_____ _____

Signature Date