Lanier Family Healthcare

Gary S. Orris M.D. *Ann Marie Peck, FNP-C*

Medical Records Release

Name of Provider/Practice/Facility: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ **Fax:** _____

Patient's full legal name: _____

Other names used while under treatment: _____

Patient date of birth: _____

Patient home address: _____

Patient home telephone number: _____

Alternate telephone number: _____

I, _____ (please print) authorize the following medical records to be released to:

Lanier Family Healthcare
5830 Bond Street, Suite 200
Cumming, GA 30040
P: 770-205-5518 F: 770-205-5519

Information to be released to:

☐ All records ☐ All diagnostic testing ☐ Consultation reports ☐ Discharge Summaries
☐ History & Physical Exam Reports ☐ Progress/Office Notes ☐ Laboratory Reports
☐ Other: (Describe) _____

I understand and specifically request that these records will include information about (check those desired, if any):

☐ AIDS/HIV Infection ☐ Psychiatric/Behavioral healthcare ☐ Treatment for drug/alcohol abuse

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, or upon the following event or condition.

_____ _____

Patient's Signature or Authorized representative **Date**

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Phone: 770-205-5518 Fax: 770-205-5519
Email: info@lfhllc.com
www.LanierFamilyHealthcare.com