Lanier Family Healthcare

Gary S. Orris M.D.   Kasin Anton, P.A.-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**