Premier Internal Medicine of Alpharetta, PC

3665 Old Milton Parkway, Suite 30
Alpharetta, GA 30005
678-369-6993 (phone) / 866-292-0442 (fax)

Medical Records Request Form

Name of Patient _____ Date of Birth _____

Address _____

What protected health information would you like released?

_____

_____

I, the signed patient or legal guardian of the patient, authorize **Premier Internal Medicine of Alpharetta, PC** to release my records **TO**:

_____

(Name of Medical Practice, Physician or Hospital)

_____

(Address) (City/State) (Zip)

_____

(Phone #) (Fax #)

BY:

- Fax
- Mail
- Patient will pick up medical records from the office.

_____

Signature of Patient or Legal Guardian

_____

Printed Name of Patient or Legal Guardian Today's Date