



Piedmont Radiology

## RADIOLOGY ASSOCIATES OF ATLANTA

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print):

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SSN \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

RELEASE MY MEDICAL RECORDS TO:

\_\_\_\_\_, MD

Piedmont Radiology  
Phone: 404-352-1409  
Fax: 404-352-8176

I AUTHORIZE PIEDMONT RADIOLOGY TO RELEASE RECORDS TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS

Patient \_\_\_\_\_ Date \_\_\_\_\_

