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The Hand & Upper Extremity
CENTER OF GEORGIA, P.C.
SURGERY OF THE HAND, ELBOW AND SHOULDER

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Authorization to Release Medical Records to

The Hand & Upper Extremity Center of Georgia, P.C.

I ________________________________, hereby authorize the release of any medical records, including office and operative notes, x-rays, and diagnostic study results to *The Hand & Upper Extremity Center of Georgia, P.C.*

Patient's Name: ____

Date of Birth: ____

Social Security #: ____

____

Signature of parent/guardian/patient requesting information Date