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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

I _____, hereby authorize *The Hand & Upper Extremity Center of Georgia, PC* to release any medical records, including office and operative notes, x -ray reports and any diagnostic study results to: _____.

Facility / Office / Doctor's Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone #: _____

Fax #: _____

Patient's Name: _____

Date of Birth: _____

Date of Service Requested: _____

Signature of parent/guardian/patient requesting information

Date