



Estate Clinics by CMG
107 Upper Riverdale Rd. SW Ste A
Riverdale, GA 30274
Phone: (770) 997-2160
Fax: (678)

**Patient Release Form
Authorization to Release Protected Health Information**

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

I, _____ **authorize,** Estate Clinics by CMG
(insert your name)

to release my protected health information to:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

This request applies to my:

- Complete medical record
- Healthcare information limited to the following conditions or dates:

Reason/Purpose for disclosure:

- Medical
- Legal
- Financial
- Personal

I have read and understood the information in this authorization.

Patient/Guardian Signature: _____ **Date:** _____