ESTATE CLINICS by CMG

Patient Release Form
Authorization to Release Protected Health Information

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

Address:_____**Phone**:_____

I,_____**authorize the following facility:**
(insert your name)

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax: :_____

to release my protected health information to:

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

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**:_____