



5361 Reynolds Street • Savannah, Georgia 31405 • (912) 355-8000 • Fax (912) 356-0229

RECORDS RELEASE FORM

Date _____

I, _____, hereby authorize the release of

records from (Doctor or Office) _____

at (address) _____

to (Doctor or Office) _____

at (address) _____

Information released is to include the diagnosis and records of any treatment

or examination rendered to me during the period from _____

to _____.

Patient name (at the time services rendered): _____

Date of Birth: _____ SS#: _____

Signature of Patient or Guardian

Address

Telephone Number