



I, \_\_\_\_\_, authorize the following protected health information  
Person Authorizing Release

Released from the medical record of: Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone# \_\_\_\_\_  
Social Security # \_\_\_\_\_

**Medical Records Released from:**

Name of Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

<b>Medical Records Released to:</b>	
<b>Evans Medical Group</b>	
<b>465 N Belair Road, Ste 1B</b>	
<b>Evans Georgia 30809</b>	
<b>706 868-3100 706 228-3125 fax</b>	
_____ Robert Lamberts, MD	_____ Michael Ikeler, MD
_____ Christopher Apostol, DO	_____ Barry Jordan, MD
_____ Maria Johnson, DO	
_____ Delores Schwartz, PA-C	_____ Lauren Wieme, PA-C

**Reason for Release of information: Primary Care Physician, coordination of care**

Please send the following:

- Most Recent**       **Last 12 months**       **Entire Chart**
- Immunization Record**       **Other** \_\_\_\_\_

I understand that this authorization is valid for six months unless I notify Evans Medical Group otherwise. I may revoke this authorization in writing at any time except to the extent that Evans Medical Group has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Evans Medical Group, Medical Records Department to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. *I understand that I may be billed per the fee schedule for medical records with the exception of records directly released from Evans Medical Group to another Professional Medical Facility.* This information will be requested in a prompt manner according to the standards of Evans medical Group provided all information has been supplied to Evans Medical Group correctly.

_____ SIGNATURE OF PATIENT PARENT / LEGAL REPRESENTATIVE	_____ Relationship	_____ DATE
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If completing on behalf of another adult, a signature is required from that individual. If you have Power of Attorney on behalf of another individual, please provide us with a copy of the legal document. POA copy attached. \_\_\_\_\_

<b>EMG Staff Only</b>	Date Released: _____	Release by: _____
	Notes: _____	08/10