EAGLE DRIVE
FAMILY MEDICINE

I authorize Eagle Drive Family Medicine to release my medical records to the following physician/facility as needed for continuation of care. I understand that records may contain any information from previous providers, information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease and I am authorizing release of this information with my signature :

Physician's/Facility Name: _____

Office Address: _____

City: _____ State_____ Zip Code: _____

Phone : _____

Fax : _____

Patient Name: _____Date of Birth: _____

Patient Signature: _____ Date: _____

Phone: 678-445-5995 - Fax: 678-445-5998
1816 Eagle Drive - Building 200, Suite B - Woodstock, GA 30189