



## AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO LANIER URGENT CARE

I, \_\_\_\_\_ authorize the following person or organization:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Fax Number: \_\_\_\_\_

to mail or fax my medical records to:

**LANIER URGENT CARE**

**1429 Thompson Bridge Rd**

**Gainesville, GA 30501**

**Phone: 770-831-5525 Fax: 770-831-5527**

I understand that this information will include any and ALL treatment plans, medication issues, history of Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, Human Immunodeficiency Virus (HIV) infection, behavioral health/psychiatric care and evaluations, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should NOT be released: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

*This form is valid for one year from patient signature date.*