AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To:_____

_____

_____

By signing this authorization, I am authorizing you to disclose the following information. Please release this information to:

Mahon Family Medicine
1786 Oak Road, Suite B
Snellville, GA 30078
Office: (770) 925-2526
Fax: (770) 921-1770

_____

_____

_____

Patient's Name_____Date of Birth_____

Under Federal law, a patient may request a copy of his or her medical records.
A fee may be charged for this service in accordance with Georgia law.

We do require **two weeks turn around once the fee of **$35.00** has been paid.**

I understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization. I also understand that this authorization shall expire, without my express revocation, three months from the date below.

Signature of patient or responsible party_____