Authorization to Release Medical Records

By agreeing below, I authorize

☐ **METRO MEDICAL ASSOCITES**
Dharmaraj Patil, M.D.
Bindu Alexander, M.D
11379 Southbridge Parkway, Suite A
Alpharetta, Georgia 30022
Tel: (770) 777-0750
Fax: (770) 777-0521

☐ **METRO MEDICAL ASSOCITES**
Dharmaraj Patil, M.D.
Anurag Kumbham, M.D.
1829 Lawrenceville Hwy
Decatur, GA 30033
Tel: (404) 292-8335
Fax: (404) 343-3737

to release my medical records to:

Name:_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

This information may be used for the purpose of treatment.

This authorization expires on: _____

I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand I may revoke this authorization at any time by notifying, in writing, the above-named doctor. However, a revocation will not affect any actions taken by the above-named doctor prior to the receipt of the revocation.

I understand I may refuse this authorization.

_____ _____
Signature of Patient or Authorized Representative **Date**

_____ _____
Print name of Guardian or Authorized Representative **Relationship**