David A. Fields, M.D., Family Care, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____

Date of Birth: _____

Social Security # _____

I hereby authorize David A. Fields M.D., Family Care, P.C. to release my medical records to:

_____

_____

_____

tele # _____

fax # _____

I hereby give special permission to release any/all information regarding:

_____ Substance abuse records

_____ Psychiatric / Mental health records

_____ HIV / Hepatitis / AIDS / STD records

This authorization will expire one year from the date signed below

_____ _____

Signature Date

96 Tara Commons Drive ■ Loganville, GA 30052 ■ (770)554-0399 ■ fax (770)554-0058