Lifetime MEDICAL CENTER P.C.

14244 HIGHWAY 515 NORTH
SUITE 100
ELLIJAY, GA 30540
(706) 698-5433 FAX (706) 698-5445

AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

Patient Name: _____ Date of Birth:_____

SSN:_____ Phone #:_____

Release information from:_____ Phone #:_____

Fax #:_____

Release information to: Alana Kent MD Phone #:(706) 698-5433

Fax #:(706) 698-5445

I, the undersigned patient/guardian, hereby authorize the Dr. releasing records listed above, to release information listed below, from the records of patient listed above.

Please release the following information- ☒check all that apply

- ☐ Progress Notes
- ☐ Labs
- ☐ x-rays
- ☐ Hospital
- ☐ Immunizations
- ☐ Other-_____

By signing this release, I agree to pay any fees that pertain to the release of my medical records. I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental illness, Drug / Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance thereof.

_____ _____

Signature of Patient / Guardian Date

_____ _____

Relationship to Patient Signature of Witness