Pandya Medical Center

www.pandyamedicalcenter.com

Release of Medical Records

FAX: 770-709-6910

Patient Full Legal Name:

Last Name, First Name, Middle

Date of Birth: _____

Mailing Address: _____

_____

Phone Number: _(_____)_____

I authorize Pandya Medical Center to:

(Please Check One)

☐ **OBTAIN** my information **FROM**: (as indicated below)
☐ **RELEASE** my information **TO**: (as indicated below)

NAME OF PROVIDER/PRACTICE/FACILITY:

Mailing Address: _____

_____

Phone Number: _( )_____
Fax Number: _( )_____

Email Address: _____

Information Requested:
(Please Check)

_____ All Records
_____ Last Office Visit Note
_____ Last Blood Work Results
_____ EKG, Stress Test, ABI, Cardiac Cath
_____ X-Rays/CT/MRI/Ultrasound
_____ Immunization Records
_____ Other: _____

Authorized Signature Date

If you wish to receive an email communication regarding your health information or records, you acknowledge that you have been advised of the risk of transmission of this information, understand that this is not a secure format, acknowledge that this information may be seen by a third unauthorized party and take full responsibility of the possible breach.

3970 Deputy Bill Cantrell Memorial Rd Suite 220, Cumming, GA 30040
11315 Johns Creek Pkwy Suite 340, Johns Creek. GA 30097
1078 Lumpkin Campground Rd Suite 100, Dawsonville, GA 30534
5670 Old Winder Hwy Suite 101, Braselton, GA 30517

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