Windermere Medical Group

Windermere Medical Clinic
3850 Windermere Pkwy., Ste 105
Cumming, Georgia 30041
Tel (678) 455-2800

WindermereMedical.com
Fax (770) 888-9998

Canton Primary Care
200 Eagles Nest Dr., Ste 300D
Canton, Georgia 30115
Tel (678) 455-3200

MEDICAL RECORDS *REQUEST*

Patient's Name _____ **Date of Birth** _____

I request / authorize: _____ TEL: _____

_____ **FAX:**_____

_____ ***REQUIRED***

_____

to release healthcare information of the patient named above to:

Windermere Medical Group
3850 Windermere Pkwy, Ste 105
Cumming, GA 30041
***FAX:* (770) 888-9998**

This request and authorization applies to:

___ All Medical Records

___ Medical Records relating to the following treatment, condition, or dates:

_____

___ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, includes: herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, gonorrhea and HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome).

__ **YES** __ **NO** I authorize the release of STD test results and/or HIV/AIDS test results.

__ **YES** __ **NO** I authorize the release of records regarding drug, alcohol, or mental health treatment.

Patient Signature: _____ **Date:** _____ **Phone #** _____

** THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED **

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AUTHORIZATION *TO RELEASE* MEDICAL RECORDS

Patient's Name _____ **Date of Birth** _____

I request / authorize: **Windermere Medical Group**
3850 Windermere Pkwy, Ste 105
Cumming, GA 30041

to release healthcare information of the patient named above to:

NAME: _____ **TEL:** _____

ADDRESS: _____ ***FAX:***_____

_____ *****REQUIRED*****

_____

This request and authorization applies to:

___ All Medical Records (Including STD/Drug & Alcohol/Mental Health records)

___ Medical Records relating to the following treatment, condition, or dates:

_____

___ Other: _____

Patient Signature: _____ Date: _____ Phone # _____

** THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED **