# ALPHA MEDICAL CLINIC

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Internal Medicine/Family Practice

Diplomate of American Board of Internal Medicine


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## Authorization to Release Medical Information

**TO:**

| Physician/Facility: | | | |
|---|---|---|---|
| Address: | | | |
| City & State: | | Zip Code: | |
| Phone: | | | |
| Fax: | | | |

**REGARDING:**

| Name: | | | |
|---|---|---|---|
| Date of Birth: | | SSN (last 4 digits): | |

I authorize and request the release of my medical records to:

Alpha Medical Clinic
401 South Main Street, Suite A4
Alpharetta, GA 30009
Office: (770) 772-4044
Fax: (770) 772-4227

Signature: ______________________________________________ Date: ____________________

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