

Carrollton Surgical Group, P. A.
157 Clinic Avenue, Suite 302
Carrollton, Georgia 30117
770-834-3336

Authorization for Release of Records to Patient Representative

Date: _____ Expiration Date: _____

Patient's name: _____ SS#: _____

Date of birth: _____

I, _____ (print patient's name) do hereby authorize
Carrollton Surgical Group, P. A. to discuss and/or release my medical information to the
individuals listed below:

Name: _____ Relationship to Patient: _____

Address: _____
Telephone Number: _____

Name: _____ Relationship to Patient: _____

Address: _____
Telephone Number: _____

Name: _____ Relationship to Patient: _____

Address: _____
Telephone Number: _____

Medical Information may include the following items.

- | | |
|--|---|
| <input type="checkbox"/> Test Results (Xray, Pathology, Lab) | <input type="checkbox"/> Surgery Related Information |
| <input type="checkbox"/> Patient Instructions | <input type="checkbox"/> Medication Related Information |
| <input type="checkbox"/> Test Preparation Information | <input type="checkbox"/> Medical Opinion |

Printed name

Signature

Date

**Please note that it is the responsibility of the patient to notify our office in writing or
by telephone if they want to remove a patient representative from this form.