Records Release Form

Name: _____ DOB: _____ DATE: _____

I hereby authorize you to release to:

_____

_____

_____

_____

Phone: _____ Fax: _____

From:

GEORGIA PULMONARY GROUP
GEORGIA SLEEP SPECIALISTS
PULMONARY DISEASE, CRITICAL CARE MEDICINE,
AND SLEEP DISORDERS
GREGORY L. MAULDIN, M.D.
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_____ Date of transfer of care: _____ Reason for request: _____

_____ All records pertaining to my medical care

_____ All records pertaining to my care with HIV

_____ Specific records as listed_____

Printed name: _____

Signature of patient or guardian: _____

Witness: _____