# PATIENT'S AUTHORIZATION TO RELEASE MEDICAL RECORDS

*For the Facility checked below:*

☐ HyperbaRXs at Kennestone *(d.b.a. Cobb Hyperbaric Medicine)*
☐ HyperbaRXs at Lithonia *(d.b.a. DeKalb Hyperbaric Medicine & Wound Care Center)*
☐ HyperbaRXs at Northside Forsyth *(d.b.a. North Georgia Center for Hyperbaric Medicine & Wound Care)*
☐ HyperbaRXs at Saint Joseph's *(d.b.a. Hyperbaric Medicine of North Atlanta)*

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*Please provide complete and accurate information when submitting this form. Only valid and complete forms will be processed.*

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (Daytime): _____ Telephone (Evening): _____

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**I authorize release of my health care information concerning:** *(please check off at least one of the following)*

☐ All health care records

☐ Treatment of *(please identify condition)*: _____

☐ Treatment received on the following dates: from _____ to _____

☐ Other *(please describe)*: _____

**I authorize:**

Facility: _____ Dr: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

**To release my private health information as identified above to:**

Facility: _____ Dr: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

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Please list the purpose or need of your health information: *(Please check one of the following)*

☐ Transfer of care ☐ Moving ☐ Seeing referred physician ☐ Other: _____

_____ _____

Patient Signature Date