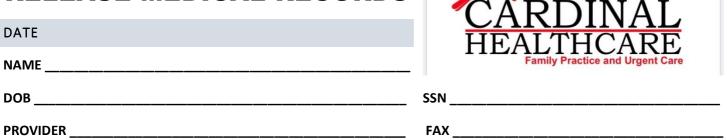
## AUTHORIZATION TO RELEASE MEDICAL RECORDS



I authorize the named Healthcare Provider to release the information or records specified to CARDINAL HEALTHCARE upon request in person, by fax, or by mail to the address or fax number specified at the time of the request.

## Records authorized to be released:

0	LABWORK DATED	FROM	_ TO
0	OFFICE NOTES	FROM	_то
0	RADIOLOGY REPORTS DATED	FROM	_то
0	CONSULT NOTES	FROM	
0	ALL RECORDS ON PATIENT	FROM	_то

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the Healthcare Provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

## I also understand that:

- o I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed and that Cardinal Healthcare may re-disclose the information.
- o I am entitled to receive a copy of this authorization.
- o A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Authorized Signature	Date
Name of Representative	
Relationship to Patient	

PLEASE FAX REQUESTED RECORDS TO (478) 412-2881 OR

MAIL TO 601 FERNCREST DRIVE SUITE 2 SANDERSVILLE, GA 31082