



Authorization for Release of Information

I, _____, do hereby authorize Roswell Urgent Care Center, LLC to release and/or disclose my medical records or my child's medical records to _____, by secure fax or email to _____ in compliance with the manner described below. I understand that this release will remain in effect no longer than 30 days from the date it is signed.

Patient Name _____

Patient DOB _____

Dates of Service _____

Records Requested

- Doctor's Notes
- Nurse's Notes
- Labs
- X-Ray
- CT/MRI or other Diagnostic Tests
- Other _____

Patient/Authorized Person Signature

Date

Witness

Date