ROSWELL
URGENT CARE

Authorization for Release of Information

I,_____, do hereby authorize,_____, at fax number _____ to release and/or disclose my medical records or my child's medical records to **Roswell Urgent Care Center by secure fax to (770) 992-4799,** 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 _____

Date(s) 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

660 W. Crossville Rd, Ste. 110, Roswell, GA 30075
Phone (770) 992-4700 • **Fax** (770) 992-4799