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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth:_____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

Facility or Physician _____

Address: _____

To:

Vishwanath Chegireddy, M.D.
1110 W Peachtree ST NW, Suite 1050
Atlanta, GA 30319

Phone: (404) 446-0044
Email: morgan@aestheraplasticsurgery.com

Please release a copy of all my medical records including but not limited to progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____