Walton Family Medicine, P.C.

P.O. BOX 671
521 Great Oaks Drive
Monroe, Georgia 30655
Phone 770-267-7093
Fax 770-267-7361

RECORD(S) RELEASE AUTHORIZATION(S)

DATE:_____

TO: _____
(Physician and/or Hospital)

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

RELEASE AUTHORIZATION FOR:

_____ **DOB:** _____

_____ **DOB:** _____

_____ **DOB:** _____

_____ **DOB:** _____

(ADDRESS) _____

_____

PHONE: _____

PLEASE SEND THE REQUIRED DOCUMENTATION TO THE ADDRESS LISTED ABOVE.

SHOULD THERE BE ANY QUESTIONS, PLEASE CALL (770) 267-7093.

I authorize the release of any medical information, including information related to psychiatric, care, drug and alcohol abuse, and AID/HIV confidential information, necessary to process insurance claims. This signature on file may also be used for medical record(s) release and transfer to this facility. I permit a copy of this authorization to be used in place of the original. I understand and agree that I am responsible for payment of all charges, regardless of insurance coverage, and/or Medicare patients. I agree to accept full responsibility for charges that are not necessary and I agree to have the services rendered in advance of this financial understanding.

SIGNATURE: _____ DATE: _____