Georgia Renal &
Hypertension Care

Medical Records Release

Patient Name: _____ Date of Birth: _____

For the purpose of continuation of medical care, I hereby request to have my medical information as described below, including but not limited to office progress notes, reports from labs and other studies, summaries of treatment, consultation reports, and verbal/telephone/e-mail contact, released to:

Georgia Renal & Hypertension Center

Vishal Ratkalkar, MD, FACP, FASN

2326 Hwy 34 East, Suite 201
Newnan, GA 30265

195 Parkwood Circle
Carrollton, GA 30117

Phone 678.664.1545 • Fax 678.664.1546

The type and amount of information to be used or disclosed is as follows:

☐ Most recent history and physical

☐ Most recent discharge summary

☐ Laboratory results from _____ to _____

☐ X-ray and imaging reports from _____ to _____

☐ Consultation report

☐ Entire record

☐ Other:

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This release will continue until termination of treatment unless otherwise specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Medical Record Services.

_____ _____

Signature of Patient/Authorized Person Date