

CHHOKAR CLINIC.
1906 Warm Springs Road.
Columbus, GA 31904
706-322-0528.

AUTHORIZATION TO RELEASE INFORMATION.

PATIENT :- _____

DATE OF BIRTH:- _____

SOCIAL SECURITY:- _____

I Hereby Authorize The Release Of The Following Information.

☐ Dr's Notes. ☐ Cardiology Report.

☐ Hospital Notes. ☐ Complete Medical Chart.

To,

Phone # _____

Fax # _____

Reason for Release: _____

I hereby release Chhokar Clinic, its employees, officers and affiliates from any and all liability, responsibility, claims and damages which may result from release of information authorized by this Consent for Release of Information.

Patient Signature.

Date.

I have received my medical record from Chhokar Clinic on _____.
