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MEDICAL RECORDS REQUEST

**AUTHORIZATION TO REQUEST A COPY OF MY MEDICAL RECORDS
TO BE FORWARDED**

Please print this page, read it carefully, fill it in, and sign it. Then mail, fax, or hand-deliver it to the address in Step 2. *This only allows a copy of your medical records to be sent. It does not affect your relationship with this physician.*

STEP 1—PATIENT INFORMATION:

Name _____ Date of Birth _____

Social Security Number _____ Phone Number _____

Address _____

STEP 2—CURRENT LOCATION OF YOUR RECORDS THAT YOU WANT COPIED

Who has your records now? _____

Address _____

Telephone _____ and/or Fax _____

STEP 3—INFORMATION YOU WANT COPIED AND RELEASED

All records *or* Dates of treatment: _____ to _____ Labs Radiology (X-Ray) films

STEP 4—LOCATION TO SEND YOUR RECORDS TO

Name _____

Address _____

Telephone _____ and/or Fax _____

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.

PATIENT SIGNATURE _____ **date** _____

Release of Sensitive Information: *I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric issues, sexually transmitted diseases, social services, hepatitis testing/treatment, HIV testing/treatment and/or sensitive information, I agree to its release.*

PATIENT SIGNATURE _____ **date** _____