



**PATIENT'S AUTHORIZATION TO RELEASE MEDICAL RECORDS**

For the Facility checked below:

- HyperbaRXs at DeKalb (d.b.a. DeKalb Hyperbaric Medicine & Wound Care Center)
- HyperbaRXs at Johns Creek
- HyperbaRXs at Kennestone (d.b.a. Cobb Hyperbaric Medicine)
- HyperbaRXs at Northside Forsyth (d.b.a. North Georgia Center for Hyperbaric Medicine & Wound Care)
- HyperbaRXs at Saint Joseph's (d.b.a. Hyperbaric Medicine of North Atlanta)

Please provide complete and accurate information when submitting this form. Only valid and complete forms will be processed.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Daytime): \_\_\_\_\_ Telephone (Evening): \_\_\_\_\_

**I authorize release of my health care information concerning:** (please check off at least one of the following)

- All health care records
- Treatment of (please identify condition): \_\_\_\_\_
- Treatment received on the following dates: from \_\_\_\_\_ to \_\_\_\_\_
- Other (please describe): \_\_\_\_\_

**I authorize:**

Facility: \_\_\_\_\_ Dr: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**To release my private health information as identified above to:**

Facility: \_\_\_\_\_ Dr: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please list the purpose or need of your health information: (Please check one of the following)

- Transfer of care
- Moving
- Seeing referred physician
- Other: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date