

Glenn L. Goodhart, M.D., J.D.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

TEL: _____

FAX: _____

TO

Glenn L. Goodhart, M.D., J.D.
Atlanta Hyperbaric & Wound Care Clinic, L.L.C.
2675 N. Decatur Rd., Suite 312
Decatur, GA 30033

Tel: (404) 501-7312
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Please send medical records no later than: _____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____

Date: _____