ATLANTA CARDIOLOGY ASSOCIATES LLC

Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

INFORMATION TO BE RELEASED

☐ History & Physical	☐ Consultation Report	☐ ER Records	☐Office notes
☐ Operative Reports	☐ Discharge Summary	☐ Face sheet	☐ Echo, EKG, results
☐ Lab/Path Reports	☐ X-ray, MRI, CT Reports/Images	☐ ALL RECORDS	

☐Other _____

The above information may be released to:

☐ **Dr. Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E**
5730 Glenridge Drive, Ste. 220, Atlanta, GA 30328
Phone: 404-796-7011
Fax: 404-796-7099 or 470-225-1124

FROM:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State, Zip) Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or other treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire 1 year from the date of my signature, unless I revoke the authorized prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient