



**MEDICAL RELEASE OF INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

This is Form intended as a Release of healthcare Information to:

**Georgia Prostate Institute**

**FAX: 404.868.3363**

I \_\_\_\_\_ (please print clearly) request and authorize the release of Healthcare Information including the diagnosis, records; physical examination, diagnostic imaging, labs and treatment plan rendered to me.

Should you have any questions, Please call my:  my home  my work  my cell  
Number: \_\_\_\_\_ Alternate number: \_\_\_\_\_

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Patient signature:

\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_AM/PM

Special Instructions/Request:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_