Georgia Internal Medicine Partners, LLC

James L. Millen, MD, CDE
Lamar B. Peacock, MD

DIPLOMATE
American Board of Internal Medicine

Authorization to Release Medical Records

Name _____ _____ _____
Last First MI

Address _____ _____ _____ _____
Street or PO Box City State Zip

Phone _____ Date of Birth _____

I authorize _____ to release medical information from my
Physician or Hospital Name and Phone #

medical record to:

Georgia Internal Medicine Partners, LLC
James L. Millen, MD - Lamar B. Peacock, MD
1203 George C. Wilson Drive, Suite B
Augusta, GA 30909
Phone: 706-447-1118 – Fax: 706-826-2775

For the purpose of review/examination. I further authorize you to provide such copies there of as may be requested. The foregoing is subject to such limitations as indicated below:

□ Entire Record

□ Specific Information: _____

□ Old records from previous physicians: _____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signature _____ Date _____

Witness _____ Date _____