Jay Medical & Rehab Works, PC
3457 Lawrenceville-Suwanee Rd., Suite C
Suwanee, GA 30024
678-714-8522 / Fax.678-714-8542

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____ **Patient Phone #:** _____

I request and authorize _____ **to release healthcare information of the patient named above to:**

Name: Jay Medical & Rehab Works, PC

Address: 3457 Lawrenceville-Suwanee rd., Suite C

City: Suwanee State: Ga Zip Code: 30024

This request and authorization applies to:

☐ **Healthcare information relating to the following treatment, condition, or dates:** _____

_____

☐ **All healthcare information**

☐ **Other:** _____

Patient Signature: _____ **Date:** _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.