

Cobb Internal Medicine Associates, P.C.

Seema Hisamud-Din, M.D.

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Board Certified

American Board of Internal Medicine

MEDICAL RECORDS RELEASE REQUEST

Patients Name: _____

Date of Birth: _____

Address: _____

Please Release My Medical Records from:

Name of Provider: _____

Providers Address: _____

To:

Cobb Internal Medicine

2655 Dallas Hwy Ste 340

Marietta Ga, 30064

Phone Number : (678) 797-9800

Fax Number : (678) 797-9801

I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and other statutory protected diseases. This authorization and consent will expire ninety days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that the action has previously taken in reliance hereof.

I hereby authorize the release of my medical records as provided above.

Signature: _____ Date: _____

(Patient, Parent or Guardian)

Witness Signature: _____

Void Date: _____