Tyrone Family Medicine

William C. Lambert, M.D. 110 Lloyd Avenue Tyrone, GA 30290 (770) 486-1200

PATIENT NAME _____ SS# (last 4 digits) _ _ _ _

DATE OF BIRTH _____ PHONE NUMBER _____

Personal medical information to be released to:

( ) _____ Purpose of Disclosure: _____ Transfer

_____ _____ Continued Care _____ Other

_____ _____ Insurance _____ Legal

( ) Tyrone Family Medicine
110 Lloyd Avenue Phone: 770-486-1200
Tyrone, Ga 30290 Fax: 770-486-3697

( ) Need Within 24 Hours

Portion of record needed: ____ Entire Record ____ ER Record ____ Radiology Reports
___ Mammo Report ___ EKG ___ Colonoscopy ___ Therapy Notes ___ Last Notes/Labs
Other: _____

I hereby authorize TYRONE FAMILY MEDICINE – WILLIAM LAMBERT, M.D. to receive/disclose/release medical records and/or information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges, if applicable, for legal, insurance, and/or personal use.

I hereby release TYRONE FAMILY MEDICINE – WILLIAM LAMBERT, M.D. from any liability which may result from this release of information. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire in ninety (90) days from the date signed.

I consent to the transfer of medical, surgical, psychiatric, substance abuse, and HIV/AIDS information.

PATIENT/GUARDIAN
SIGNATURE_____

Witness/Tyrone Family Medicine Staff _____

Please email completed form to: tyronefamilymed@bellsouth.net