



AUTHORIAZATION FOR MEDICAL RECORD RELEASE

Patient Information: Name: _____
DOB: _____
SSN: _____
Phone: _____

Medical Records Requested from: Name: _____
Phone: _____
Fax: _____

Please release my records to: **Scott Greer, M.D.**
Auburn Pediatric and Adult Medicine
861-A North Dean Road
Auburn, AL 36830
Phone: (334) 887-8707
Fax: (334) 887-8706

*****Please Fax if Possible*****

- Please Send: Just the basics (summary, op notes, consults, H&P's, labs, tests)
 Immunization history & growth curves
 Everything possible

By my signature I authorize release of medical records, and for this form to be sent to the medical provider listed above

Patient/Guardian Signature

Date

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