2870 Ronald Reagan Blvd
Suite 200
Cumming, GA 30041

MICKY MISHRA, MD FACC

Phone: 404-994-4561
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REQUEST FOR RELEASE OF MEDICAL RECORDS

This form to be used if we need to get records from a previous physician or previous hospital stay.

TO:

____

Name of Healthcare Provider/Physician/Facility

____

Street Address

____

City, State and Zip Code

____

Phone Number **Fax Number**

I authorize and request the release and disclosure of any and all medical information pertaining to the below patient protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information be released **to: North Atlanta Cardiology, P.C. 2870 Ronald Reagan Blvd. Suite 200 Cumming, GA 30041**.
I further authorize that a copy of this medical authorization may be used in lieu of the original. I also understand that I can revoke this authorization at any time in writing, revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

Please Print Below:

Patient Name:____ **Date:**______________________

DOB:____ **SSN:**____________________________________

Address:____

____

____

Patient Signature **(or authorized representative)** ____

Name of Representative: ____________________________________ **Relationship**_____________________
(print)