Kenneth Harper, M.D., P.C.

5910 Hillandale Drive • Suite 301 • Lithonia, Georgia 30058
Phone (678) 418-2120 • Fax (678) 418-2936

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date Of Birth: _____
Last First Middle

SSN: _____ hereby request that my records be released from:

_____
Physician or Institution

_____
Street Address

_____
City, State, and Zip Code

_____
Physician FAX Physician Phone

Entire Medical Record □ Most recent lab/x-ray results □ Other: _____

To:

Kenneth Harper, MD, PC
5910 Hillandale Drive, Suite 301
Lithonia, GA 30058

I understand that by transferring my entire medical record means that I am transferring my Primary Care Physician (PCP) to Kenneth W. Harper, MD or Paula Pollard-Thomas, MD.

_____
Signature of Patient or Guardian Date of request

Witness _____ Date signed _____

Request sent on _____ via U.S. Mail □ fax □