SweetwaterPractice
Counseling & Consulting

Records Release Form

Patient Name: _____ DOB: _____

_____ I authorize Sweetwater Practice to release my records in their entirety to:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

_____ I authorize Sweetwater Practice to release my progress notes in their entirety to:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

You have my permission to deliver these via fax, email, regular mail, or personal delivery.

_____ I authorize _____ to release my medical records to:

Sweetwater Practice, LLC
455 East Paces Ferry Road
Suite 204
Atlanta, Georgia 30305
Fax: 404-988-2612

_____ _____
Patient signature Date