GENESIS HEALTHCARE ASSOCIATES, P.C.

MEDICAL RECORD RELEASE FORM

Date ____________________________

Patient Name ____

Date of Birth _____________________

SS# ______________________________

Physician's Name ____

Address ____

City _____________________________ State _______________________ Zip ___________

I hereby authorize you to release the medical record/s of _____________________ __________________________________. to Genesis Healthcare, P.C. You may either fax these records to our medical records department, at (770) 434-1304, or you may mail them directly to:

Genesis Healthcare, P.C.
3200 Highlands Parkway, Suite 250
Smyrna, Georgia 300802
Phone Number: (770) 434-1904 Fax
Number: (770) 434-1304

Patient Signature ____