RECORDS TRANSFER REQUEST

Date:________________

To:____
(Doctor/Hospital)

Address:____

City, State, ZIP:____

Telephone:____

I hereby authorize the release of my medical records or copies of such and request that they be transferred to:

Adult Primary Care Associates
of Greater Gwinnett, LLC
575 Professional Drive
Suite 510
Lawrenceville, GA 30045
770-513-2072
www.adultprimarycareagg.com

Print Name of Patient______________________ **Signature**________________________________
(Patient, Parent or guardian)