



229 Athens Street
Hartwell, Georgia 30643
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E. Wade Walker, M.D. • JoDon Garringer, M.D. • B. Jamison White, D.O.
MacKenzie Cheek, NP-C • Brad Jones, FNP • Austin Darbyshire, FNP

Patient's name

Social Security

Date of Birth

Which physician at Hartwell Family Practice would you like to receive your records?

_____ E. Wade Walker, M.D.

_____ MacKenzie Cheek, NP *

_____ B. Jamison White, D.O.

*NEW PATIENTS PLEASE NOTE: If you choose an NP provider and are accepted as a patient, your first visit to the practice will be with a MD/DO provider and future visits will be with your accepting NP.

_____ JoDon Garringer, M.D.

_____ Any Provider

From whom do you wish to forward your medical records to Hartwell Family Practice, P.C.?

Name of person/Facility, Address, Phone or fax number as applicable

Please forward the following information to Hartwell Family Practice, P.C.

() NEW PATIENT REQUEST: H&P, medication list, & last 3 office notes and labs

() complete medical record () partial record () specific date _____

Including information in reference to: (check all that apply)

() drugs and/or alcohol abuse

() Psychiatric

() venereal disease

() Social services

() Hepatitis B testing/treatment

() HIV testing/treatment

() Other _____

Why are you requesting that your records be sent to Hartwell Family Practice?

This authorization is valid for 90 days and may be revoked in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release Hartwell Family Practice, P.C. from any liability or legal responsibility in connection with the release of the above information. I do not give permission for any other use or re-disclosure of this information.

I also accept the risk and consequence of faxing medical records.

Patient Signature

Guardian Signature (if under 18)

Telephone

Date

****PLEASE MAIL/FAX RECORDS TO THE ADDRESS ABOVE ****

Below is for HFP Use Only

Date Sent: _____ Initial: _____