I hereby request and authorize ____ to release information from the medical record of:

PATIENT NAME: ____

DATE OF BIRTH: ____

ACCOUNT NUMBER: ____

Information requested to be released: MEDICAL RECORDS

From: ____

____

____

To: Atlanta Personalized Medicine LLC

775 Johnson Ferry Rd NE

Atlanta, GA 30342

The reason for releasing this information: PRIMARY CARE PHYSICIAN

I hereby give permission to release the information requested on this form including release of information relating to: psychiatric records, psychotherapy notes, alcohol and/or drug abuse records; HIV/AIDS information; genetic testing, and/or sexually transmitted disease information (if applicable) to the individual/agency listed above and only for the purposes I have indicated. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing.

____ ____________________________

Patient signature Date