OFFICE OF THE DISTRICT ATTORNEY
NORTHEASTERN JUDICIAL CIRCUIT

LEE DARRAGH
District Attorney

P. O. Box 1690
Gainesville, Georgia 30503
770.531.6965
Fax: 770.531.6970

AUTHORIZATION TO RELEASE INFORMATION

TO: _____

PATIENT: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

TREATMENT DATES: _____

PORTIONS OF THE RECORD NEEDED:

___EMERGENCY ROOM RECORDS
___PHYSICIANS NOTES
___NURSES NOTES
___DRUG AND ALCOHOL SCREENS
___ENTIRE MEDICAL RECORD
___THERAPY RECORDS
___RADIOLOGY REPORT
___DISCHARGE SUMMARY
___OTHER _____
___FINAL BILLING STATEMENT
___X-RAYS

I hereby authorize the above named physician/medical care provider to release the requested medical records pertaining to my treatment on the specified dates. I also understand that I have the right to withdraw my consent in writing at any time prior to the release of the requested information. This authorization shall expire one year (365 days) from today's date _____.

Information may be released to: Hall County District Attorney's Office

___ Mail to
PO Box 1690
Gainesville, GA 30503

___ Make Available for Pickup

___ Fax records to
770-531-6970

Certify Records ____Yes ___No

_____ _____
PATIENT SIGNATURE DATE

_____ _____
WITNESS DATE

PLEASE REFER ANY QUESTIONS TO THE DISTRICT ATTORNEY'S OFFICE 770-531-6965

DISTRICT ATTORNEY'S OFFICE USE ONLY:
REGARDING: CRIMINAL CASE, STATE VS._____