**Release of Medical Records**

Name of practice obtaining records from_____

Office Pone Number_____Fax Number_____

Address_____
_____

I give permission for my medical records (blood work, Chart, EKG) to be released to:

Dr. Place Weight Loss And Wellness Center
4480 N Cooper Lake Rd Suite 220
Smyrna, GA 30082
Fax to: 770-431-2321  Phone: 770-431-2322

Printed Name:_____ D.O.B _____

Signature: _____

Date: _____