RIMGroup
REBOUND INTEGRATIVE MEDICAL GROUP

155 Westridge Parkway, Suite 106
McDonough, Ga 30253
Ph: 678-902-4RIM **(Main)**
Ph: 706-405-5830 (Columbus, Ga)
Fax: 1-844-765-5644

RELEASE OF MEDICAL RECORDS

PLEASE PRINT

Name: _____ **Date of Birth:** _____

S-S-N: _____

I authorize the release of my medical records: (Check all that apply)

□ Office/Hospital visit notes, Surgical notes, Procedure notes, other:

_____

□ Radiographic Reports (i.e CT scan, MRI, Xray, Bone Scan, Ultrasound, etc..), other:

_____

□ Radiographic images (CD, hard copy film) □ Discharge Summary □ Medication List

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I understand that a charge of $25.00 will be incurred for copies of medical record/documentation requested by me or a third party from Rebound Integrative Medical Group. I do hereby authorize the release of my medical records

FROM: (check the box that applies)

☐ Rebound Integrative Medical Group
155 Westridge Parkway, Suite 106
McDonough, Ga 30253

☐ Name/Facility:
_____

Address:
_____

Phone/Fax:
_____

Please send a copy of my medical history and records in your possession **TO: (check the box that applies)**

☐ Name of Recipient:_____

Practice/Facility:_____

☐ **Rebound Integrative Medical Group • Fax: 1-844-765-5644 • Phone: 678-902-4RIM**

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Witness Signature Date