# Authorization for Release of Information


Naomi Akita MD
10475 Medlock Bridge Road, Ste 810
Johns Creek, GA 30097
(Ph) 470-771-2436
**(Fax) 470-545-8673**


Patient Name: ______________________________ Birthdate: ________________________

To Facility/Doctor:

__________________________________________________________________________

Phone: ________________________________ Fax: _______________________________

I hereby authorize the disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information that I authorize a person or entity to receive may be re-disclosed and no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying Dr. Akita in writing.

To: Naomi Akita MD
Fax: 470-545-8673
Requested Documents: ____________________________________________________________

***Please fax our office the medical records, as our office does not accept mailed records**

Patient/Authorized Person Signature: Date:

________________________________________ ________________________