**Acupuncture & Injury**

**1521 Johnson Ferry Rd Suite #135**

**Marietta, GA 30062**

**PH: 678-247-2115 Fax: 404-393-8059**

**Release of Records Authorization**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**To:**

**This authorizes you to send to:**

**Acupuncture & Injury**

**James Granger, MD**

**1521 Johnson Ferry Rd Suite #135**

**Marietta, GA 30062**

**PH: 678-247-2115 Fax: 404-393-8059**

**Any and all medical records which you have obtained that may be relative to my medical care and treatment. This authority extends to the furnishing of the original medical records. However, a copy of the originals will suffice. Please include any and all reports of CT scans, MRI’s, X-ray's and labs.**

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**Patient or Guardian Signature** **Witness Signature**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_Sex: M F**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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