buckhead internal medicine

Nan R. Monahan, M.D.

Catherine L. Dekle, M.D.

Authorization Of Medical Records To Buckhead Internal Medicine

Authorization to release medical records to:

_____ Nan R. Monahan, M.D.

_____ Catherine L. Dekle, M.D.

Please mail records or fax records to the below address. I realize that any copying charge will be billed to me at my home address.

Patient's Full Name: _____

Date of Birth: _____ Phone Number_____

Home Address: _____

City: _____State: _____Zip: _____

Patient Signature: _____ Date: _____

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