Patient's Name: _____ DOB: _____

Prior Doctor/Clinic/Hospital: _____

I request and authorize the above listed medical offices/providers to release healthcare information of the patient named above to:

Med2You, LLC
411 South Greenwood Street
LaGrange, Georgia 30240

Phone: (706) 890-0687 Fax: (706) 890-0687

This request and authorization apply to:

Healthcare information relating to the following treatment, condition, or dates:

All Healthcare Information

Other:

Yes ◉ No ○
I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive to person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes ◉ No ○
I authorize the release of any records regarding drug, alcohol, and mental health treatment to the person(s) listed above.

Patient Signature: _____Date: _____

411 South Greenwood Street/ LaGrange, GA 30240/ 706.890.0687/
med2you-help@outlook.com

RESET