Atlanta Women's
OBSTETRICS & GYNECOLOGY, PC
Women Proudly Caring for Women

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Atlanta, GA 30309
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Answering Service (404) 609-0358

Medical Records Request

I do hereby authorize Atlanta Women's Obstetrics & Gynecology, PC to

☐ Release all medical information pertaining to me ☐ Request all medical information pertaining to me from:

_____

As allowed according to patient confidentiality laws with the exception of _____ for the purpose of

☐ Moving away ☐ Personal copy ☐ Transfer to new physician ☐ Second opinion

☐ Another treating physician ☐ Other _____

The following types of records will be excluded unless specifically requested. Please specifically include records pertaining to:

☐ Psychiatric Care ☐ Drug/Alcohol Abuse ☐ HIV/AIDS

The records should be:

☐ Sent to me at my home address on file

☐ Sent to Atlanta Women's Obstetrics & Gynecology, PC

☐ Sent to the following person(s)

Name: _____

Address: _____

City State Zip: _____

Phone: _____

Facsimile: _____

This Authorization shall remain in effect until revoked by me in writing. If not revoked by me in writing, the Authorization shall remain in effect for one (1) year from the date of the signature below. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this Authorization Form. I understand that if I wish to revoke this Authorization, I must do so in writing and present my written revocation to Atlanta Women's Obstetrics & Gynecology, PC. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.

_____	_____	_____
Patient Name:	Date of Birth	Social Security Number
_____	_____	_____
Signature	Date	Relationship to Patient

When a representative of the patient signs this form, the representative must provide a description of such representative's authority to act for the patient: _____.