



PEACHTREE WOMEN'S SPECIALISTS, P.C.

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RELEASE OF MEDICAL RECORDS

Patient's Name _____ DOB _____

Address _____ City _____ State _____

Zip Code _____ Home Phone _____ Cell Phone _____

MEDICAL RECORDS RELEASED FROM:

Name _____ Address _____

Suite # _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____

MEDICAL RECORDS SHOULD BE SENT TO:

Name _____ Address _____

Suite # _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____

INFORMATION TO BE DISCLOSED

___ Complete Medical Records (Including HIV, STD Screening)

___ Specific Labs Dated _____ Specify Lab _____

___ Date of Medical Records: from _____ to _____

___ Other (Please Specify) _____

REASON FOR REQUEST

___ Out of town move ___ Change in Insurance ___ Insurance Claim ___ Legal ___ Consult/2nd Opinion

___ Personal Copy ___ Transfer Care ___ Other

REVOCATION

I understand that this authorization will be in effect for **SIX (6) MONTHS**, unless cancelled by me in writing.

Patient/Guardian Signature _____ Date _____

A FEE FOR THE PROCESSING OF MEDICAL RECORDS MAY APPLY