



PEACHTREE
WOMEN'S SPECIALISTS

Obstetrics and Gynecology

RELEASE OF MEDICAL RECORDS

Patient's Name _____ DOB _____

Address _____ City _____ State _____

Zip Code _____ Home Phone _____ Cell Phone _____

Medical Records Released From:

Name: _____ Address: _____

Ste _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____

Medical Records Should Be Sent To:

Name: _____ Address: _____

Ste _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____

Information Requested:

_____ Complete Medical Records (including all labs)

_____ Specific Labs Dated _____ Specify Lab _____

_____ Dates of Service From _____ to _____

_____ Other (Please Specify)

Reason For Request:

_____ Out of Town Move _____ Insurance Change _____ Insurance Claim

_____ Legal _____ Second Opinion _____ Personal _____ Transfer of Care _____ Other

I UNDERSTAND THAT THIS AUTHORIZATION WILL BE IN EFFECT FOR SIX (6) MONTHS, UNLESS CANCELLED BY ME IN WRITING.

Patient or Guardian Signature _____ Date _____

A FEE FOR THE PROCESSING OF MEDICAL RECORDS MAY APPLY