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

Atlanta: 275 Collier Road, NW • Suite 250 • Atlanta, GA 30309 **Brookhaven:** 3925 Peachtree Rd Suite 240 • Atlanta, GA 30319
Vinings: 3020 Paces Mill Road • Suite 225 • Atlanta, GA 30339 **Phone:** (404) 355-1285 • **Fax:** (404) 351-5840