PEACHTREE WOMEN'S CLINIC

A DIVISION OF ATLANTA WOMEN'S HEALTH GROUP, PC

Medical Records Release

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Suite 200
Atlanta, GA 30342
404-255-8022
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Cumming
1800 Northside Forsyth
Suite 250
Cumming, GA 30041
770-888-0188
Fax: 770-770-888-3358

Canton
460 Northside Cherokee Blvd
Suite 360
Canton, GA 30115
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Fax: 770-255-2551

Midtown
1110 W. Peachtree St.
Suite 810
Atlanta, GA 30309
470-875-1050
Fax: 470-875-1051

Authorization to Obtain, Release or Review Protected Health Information (PHI)

I _____
Print Name DOB PWC ID#

hereby authorize PEACHTREE WOMEN'S CLINIC

Please check one:

- □ **to obtain from Dr.**
- □ **to release to Dr.**
- □ **to release to me (enter your home address below)**

_____

(Name of Doctor) (Phone #)

_____

(Address) (Fax #)

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The forgoing is subject to such limitation as indicated.

□ All medical information and reports
□ Laboratory reports
□ Sexually transmitted disease reports
□ Other (Please specify) _____
□ Prenatal medical records
□ Immunizations
□ Psychiatric/Psychological reports
□ Physical exam reports
□ Radiology (x-ray) reports
□ HIV/AIDS test results

I gave special permission to release any information regarding: (initial on applicable line(s) below)

_____ HIV Information _____ Substance Abuse _____ Psychiatric/Mental Health Info.

Reason for Request: _____

This authorization will automatically expire (1) year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date _____
(If not patient, state relationship)

Witness _____ Date _____

For Office Use Only

Received _____ Completed by _____ Completed _____ Fee Paid _____

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