

Medical Records Authorization

Release Records To:

***Modern Obstetrics & Gynecology
of North Atlanta, P.C.***
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6335 Hospital Pkwy, Suite 204
Johns Creek, GA 30097
Phone 404-446-2496 Fax 404-446-2497

Release Records From:

Name: _____

Address: _____

City: _____ State _____ Zip _____
Phone _____
Fax _____

Patient Information

Patient Name: _____

Address: _____

City: _____ State _____ Zip _____

Primary Phone # _____ Secondary Phone # _____

Date of Birth _____ Social Security Number: _____

I, _____ authorize the above listed person/s physician/s, firm or entity (or its agents, representatives, or employees) to release for inspection and copying any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from date/s of: _____ to _____.

Entire Record Radiology/X-Ray Reports Operative Reports Pathology Reports

Laboratory Records ER Reports Labor & Delivery Records

Discharge Summary Other: _____

Reason for Requesting Records: _____

Signature of Patient or Legal Representative

Date

Witness

Special Authorization to Release HIV/AIDS Information

I hereby authorize my HIV/AIDS information to be released to the party listed above

Signature _____ DOB _____ Date of Authorization _____