

**Gwinnett OB/GYN
1800 Tree Lane
Suite 300
Snellville, GA 30078**

AUTHORIZATION TO REQUEST A COPY OF MY MEDICAL RECORDS TO BE FORWARDED

Please read this page carefully, fill in and sign. This allows a copy of your medical records to be sent.

PATIENT INFORMATION:

Name _____ Date of Birth _____

Address _____

Telephone number _____

SECTION BELOW MUST BE COMPLETED ENTIRELY TO RECEIVE YOUR RECORDS

CURRENT LOCATION OF YOUR RECORDS THAT YOU WANT COPIED AND FORWARDED:

Name of Physician or Group _____

Address _____

Telephone number _____ Fax number _____

LOCATION TO SEND YOUR RECORDS:

Name of Physician or Group _____

Address _____

Telephone number _____ Fax number _____

Information to copy and release:

All records _____ or Dates of treatment _____ to _____

Reason for request of records: _____

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. I understand that my medical record may contain information in reference to psychiatric issues and/or HIV testing/treatment.

PATIENT SIGNATURE _____

DATE _____