Covington Women's Health Specialists, LLC
Obstetrics & Gynecology
p: 770.385.8954 fax: 770.385.8590
4181 Hospital Drive, Suite 104, 100, Covington, Georgia 30014

Request to Release/Obtain Medical Records

Date: _____

_____ _____
Patient Name Date of Birth

I hereby request and authorize Covington Women's Health Specialists, LLC to release/obtain my medical records including office notes, laboratory results and radiology reports from:

_____
Name of Doctor or Hospital

_____ _____
Fax Number Phone Number

For the following types of information from my records (and any specific portion thereof):

( ) Completing requested consultation
( ) Transfer of Care
( ) Other _____

I understand this authorization included release of all medical records including HIV results, records of psychiatric evaluation, drug or alcohol abuse treatment records and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time to the extent that action has previously been taken in reliance thereof.

( ) Records released to patient
( ) Sent via mail and/or fax

_____
_____

_____ _____
Patient or Person Authorized to consent for patient Date

_____ _____
Relationship to patient Witness