KENNESAW
GYNECOLOGY

1595 Kennesaw Due West Road NW
Kennesaw, GA 30152
P: 470-308-3365 F: 770-627-5228

Authorization to Release Medical Records/Information

Patient's Name_____ Date of Birth_____SSN_____

Address_____ Phone_____Number_____

Physician to *provide* Records _____ Phone: _____ Fax: _____

Physician to *receive* Records _____ Phone: _____ Fax: _____

RECORDS TO BE RELEASED:

- ☐ ALL RECORDS
- ☐ ANNUAL/PHYSICAL EXAM
- ☐ PAP SMEARS
- ☐ MAMMOGRAPHY REPORTS
- ☐ PRENATAL REPORTS
- ☐ OPERATIVE REPORTS
- ☐ PATHOLOGY REPORTS
- ☐ LAB RESULTS
- ☐ BIOPSY REPORTS
- ☐ ULTRASOUND REPORTS
- ☐ OTHER (SPECIFY) _____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THE SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED, OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXECPTION of: *(ONLY check if you do NOT want the following information sent)*

- ☐ SUBSTANCE ABUSE
- ☐ AIDS/HIV
- ☐ PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS
- ☐ OTHER (PLEASE SPECIFY) _____

Expiration or revocation of authorization: I understand that I may revoke this authorization atany time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Use of copies: a copy of this authorization may be utilized with the same effectiveness as an original.

Patient's Name (Print) _____

Signature_____ Date _____

PERSON AUTHORIZED TO SIGN FOR PATIENT:

Name (Print) _____ Relationship _____

Signature_____ Date _____