AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient/guardian, hereby request and authorize Dr._____
Address: _____

To release information listed below from the records of:

_____ _____
Patient Name Patient Date of Birth

Please provide the following information on the above patient from _____ to _____

_____ Pap smear report
_____ Biopsies
_____ Office notes
_____ Surgery information
_____All Lab-Pathology-Radiology Reports
_____ All medical records

Please send my information to:

Piedmont OB-Gyn, Attn: Dr._____
275 Collier Rd., Suite 100-A
Atlanta, GA 30309

Tele: 404-352-1235 Fax: 404-605-8805
(Please do not FAX more than 10 pages)

I understand this authorization includes the release of all medical records (unless otherwise noted) to include HIV records, psychiatric mental illness, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. **This authorization will expire when revoked by me in writing, or in one year.**

I understand that I may revoke this authorization at any time in writing, but that it cannot be retroactively revoked.

_____ _____
Patient Signature Date