Piedmont OB-GYN

A Division of *Atlanta Women's Healthcare Specialists, LLC*
275 Collier Rd, Suite 100-A
Atlanta, Georgia 30309
Tel: 404-352-1235 Fax: 404-605-8805

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient/guardian, hereby request and authorize: Piedmont OB-Gyn, a Division of AWHS,

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: _____

Address: _____
Street, City, State, Zip

Fax number: _____ Telephone number: _____

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