Gwinnett OB-GYN Associates, P.C.

1700 Tree Lane Road
Suite 290
Snellville, Georgia 30078
770-972-0330
770-985-2683 (Fax)

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

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

PATIENT INFORMATION:

Name_____Date of Birth_____

Social Security Number_____Phone Number_____

Address_____

_____

CURRENT LOCATION OF YOUR RECORDS THAT YOU WANT COPIED:

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_____
- ☐ Labs

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_____