Gwinnett OB-GYN Associates

1700 Tree Lane Road, Suite 290, Snellville, GA 30078
770-972-0330 / Fax 770-985-2683

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

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

PATIENT INFORMATION:

Name ____ Date of Birth ________________

Address ____

____

Telephone number ____

CURRENT LOCATION OF YOUR RECORDS THAT YOU WANT COPIED AND FORWARDED:

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______________________

Reason for request of records: ____

____

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**________________