Cartersville
OB/GYN ASSOCIATES
Delivering the Exceptional Care You Deserve

MEDICAL RECORDS AUTHORIZATION FORM

PATIENT NAME:_________________________________ DATE OF BIRTH:_______________

ADDRESS:____

PHONE #:______________________________ SOCIAL SECURITY:_______________________

I AUTHORIZE CARTERSVILLE OB/GYN TO **OBTAIN** MY MEDICAL RECORDS

***FROM:**____
_

ADDRESS:____

PHONE #:___________________________________ FAX #:______________________________

OR

I AUTHORIZE CARTERSVILLE OB/GYN TO **RELEASE** MY MEDICAL RECORDS

***TO:**____

ADDRESS:____

PHONE #:___________________________________ FAX #:______________________________

CIRCLE THE REQUESTED INFORMATION: PAP SMEARS, OPERATIVE REPORTS, H&Ps, BIOPSY REPORTS, DISCHARGE REPORTS, X-RAYS, PATH & LAB REPORTS, PRENATALS, OR ALL RECORDS.

PATIENT SIGNATURE:____

DATE:______________________________ **WITNESS:**_____________________________________

MEDICAL RECORDS MAY CONTAIN THE FOLLOWING INFORMATION:
OFFICE NOTES, TREATMENT, HOSPITALIZATION, AND/OR CARE FOR PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, DRUG ABUSE, ALCOHOLISM, CONTAGIOUS, COMMUNICABLE OR VENERAL DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR TEST FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV). PATIENTS REQUESTING MEDICAL RECORDS WILL BE CHARGED A FEE OF $10.00, AND DOCTORS REQUESTING MEDICAL RECORDS REQUIRE NO FEE.