Gwinnett's Progressive Healthcare for Women

REQUEST FOR MEDICAL RECORDS
FROM GWINNETT'S PROGRESSIVE HEALTHCARE FOR WOMEN

Name: _____ _____ **Date of birth:** _____
Last First Middle Maiden

Address: _____
Street Apt #/Suite City State Zip Code

Home #: _____ **Work #:** _____ **Cell #:** _____ **Email Address:** _____

I do hereby authorize: Gwinnett's Progressive Healthcare for Women **Phone #:** 770.339.4000

To Release:

- ☐ Entire record
- ☐ Pap Smear
- ☐ Mammogram
- ☐ Bone Density
- ☐ Office notes
- ☐ Lab reports_____
- ☐ Pathology_____
- ☐ Hospital records
- ☐ Operative notes
- ☐ Other:_____

Specific dates_____

IMPORTANT: PLEASE CIRCLE ONE:
I DO / DO NOT … authorize release of information related AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, sexually transmitted diseases, genetic testing, psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse

Send Records to: _____

ATTENTION: _____ **Phone:** _____ **Fax:** _____

Address: _____
Street Apt #/Suite City State Zip Code

Purpose of disclosure:

- ☐ Referral to specialist
- ☐ PCP
- ☐ Change of provider
- ☐ Personal
- ☐ Insurance
- ☐ Disability
- ☐ Worker's compensation
- ☐ Legal
- ☐ Other_____

I do hereby authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of the signature. I understand that I may cancel this request with a written notification, but it will not affect any information released prior to cancellation.

_____ _____
Signature of Patient or Authorized Person Date

_____ _____
Witness Date