Atlanta Obstetrics & Gynecology Associates, P.C.
275 Collier Road, NW
Suite 100-C
Atlanta, Georgia 30309
Telephone 404-355-0320 Facsimile 404-351-0909

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date _____

Name of Physician/Medical Facility _____

Address _____

City, State Zip Code _____

Telephone Number _____

Fax Number _____

I hereby request that a copy of my medical records be released **to: Atlanta Obstetrics & Gynecology Associates, P.C.**

Please ☐ mail ☐ fax my records to the address/fax number shown above.

Thank you for your assistance.

_____
Patient Signature

_____
Printed Name

_____ _____
Date of Birth Social Security Number

_____
Other names under which my account might be located?

If you have trouble locating my records, I may be reached:

_____
Home Address

_____
City, State, and Zip Code

_____ _____
Home Phone Work Phone