REQUEST FOR MEDICAL RECORDS
TO BE SENT TO 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: ____Phone#___________________ Fax #______________

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

To Release:

- ☐ Entire record
- ☐ Pap Smear
- ☐ Mammogram
- ☐ Bone Density
- ☐ Office notes
- ☐ Lab reports_____________
- ☐ Pathology______________
- ☐ Hospital records
- ☐ Operative notes
- ☐ Other:_________________

Specific dates_____________________

I do/ do not authorize release of information related to 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: Gwinnett's Progressive Healthcare for Women
601-A Professional Drive, Suite 260
Lawrenceville, GA 30046
Phone: 770.339.4000 Fax: 770.339.9037

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