Atlanta Obstetrics & Gynecology Associates
275 Collier Road, NW, Suite 100-C
Atlanta, Georgia 30309
Telephone 404.355.0320 Fax 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 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