ALPHA OB GYN
2905 Jordan Court, Suite G, Alpharetta, GA 30004 678 335 9223 Fax 678 335 9236

MEDICAL RECORDS RELEASE REQUEST

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Patient's Phone #: _____

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying Alpha OBGYN in writing.

To/From:	**To/From:**
Alpha OBGYN	Name: _____
2905 Jordan Court Suite G,	Address: _____
Alpharetta, Ga 30004	City/Sate/Zip: _____
Phone #: (678)335-9223	Phone #: _____
Fax #: (678)335-9236	Fax #: _____

***Please note, there will be a Fee of $35.00 if the records are released to you.**

Information Needed:

☐ Operative Notes(s)

☐ Office Records

ALPHA OB GYN
2905 Jordan Court, Suite G, Alpharetta, GA 30004 678 335 9223 Fax 678 335 9238

☐ Prenatal record, including laboratory and ultrasound reports, from the current pregnancy

☐ Lab and/or radiology reports

☐ Other_____

Signature of Patient: _____Date signed_____