



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:

Alpha OBGYN
2905 Jordan Court Suite G,
Alpharetta, Ga 30004
Phone #: (678)335-9223
Fax #: (678)335-9236

To/From:

Name: _____
Address: _____
City/Sate/Zip: _____
Phone #: _____
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

This message is intened only for the use of the individual or entity to which it is addressed and may contain information that is confidential and protected by state and federal law. If the reader of this message is not the intened recipient, or the employee or agent responsible for delivering the message to the intened recipient, you are hereby notified that any dissemination, distribution, forwarding, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by e-mail or telephone, and delete the original message immediately. Thank you!



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- Prenatal record, including laboratory and ultrasound reports, from the current pregnancy
- Lab and/or radiology reports
- Other _____

Signature of Patient: _____ Date signed _____

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