**REQUEST FOR MEDICAL RECORDS**

**FROM 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:** Gwinnett’s Progressive Healthcare for Women **Phone #:** 770.339.4000

**To Release: Specific dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Entire record
* Pap Smear ***I do/ do not*** authorize release of information related to AIDS
* Mammogram (acquired immunodeficiency syndrome) or HIV (human
* Bone Density immunodeficiency virus) infection, sexually transmitted
* Office notes diseases, genetic testing, psychiatric care and/or
* Lab reports\_\_\_\_\_\_\_\_\_\_\_\_\_ psychological assessment and/or treatment for
* Pathology\_\_\_\_\_\_\_\_\_\_\_\_\_\_ alcohol and/or drug abuse.
* Hospital records
* Operative notes
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Send Records to:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Apt #/Suite City State Zip Code

**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