Lisa Ortenzi, MD, FACOG
Suzanne Csorna, MSN, ANP-BC, WHNP-BC
Maquissa Thomas, MS, WHNP-BC, RNC-MNN

AUTHORIZATION AND REQUEST FOR RELEASE OF MEDICAL RECORDS TO DOUGLAS WOMEN'S CENTER, PC

DATE: _____

TO: _____
Name of Doctor or Hospital Requesting Records From

ADDRESS: _____

_____

PHONE #: _____ **FAX#:** _____

I hereby authorize you to release to: **DOUGLAS WOMEN'S CENTER, PC**
880 CRESTMARK DRIVE, SUITE 200
LITHIA SPRINGS GA 30122
PHONE: 770-941-8662

ATTENTION PROVIDER: _____

THE COMPLETE HISTORY IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD:

FROM _____ **TO** _____

PATIENT NAME: _____**DOB:** _____

ADDRESS: _____

PATIENT/LEGAL REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

PATIENT UNABLE TO SIGN BECAUSE:_____

WITNESS: _____ **DATE:**_____

COMMENTS: _____

_____

_____

Revised 07/18/2018