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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 07/24/2015