Georgia Advanced Surgery Center for women
Experts in Minimally Invasive Gynecological Care

MEDICAL RECORDS AUTHORIZATION FORM

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

PHONE #:_____ SOCIAL SECURITY:_____

I AUTHORIZE THE GEORGIA ADVANCED SURGERY CENTER FOR WOMEN TO **OBTAIN** MY MEDICAL RECORDS

***FROM:**_____

ADDRESS:_____

PHONE #:_____ FAX #:_____

OR

I AUTHORIZE THE GEORGIA ADVANCED SURGERY CENTER FOR WOMEN TO **RELEASE** MY MEDICAL RECORDS

***TO:**_____

ADDRESS:_____

PHONE #:_____ FAX #:_____

CIRCLE THE REQUESTED INFORMATION: PAP SMEARS, OPERATIVE REPORTS, H&Ps, BIOPSY REPORTS, DISCHARGE REPORTS, X-RAYS, PATH & LAB REPORTS, OR **ALL RECORDS**.

PATIENT SIGNATURE:_____

DATE:_____ **WITNESS:**_____

MEDICAL RECORDS MAY CONTAIN THE FOLLOWING INFORMATION:
OFFICE NOTES, TREATMENT, HOSPITALIZATION, AND/OR CARE FOR PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, DRUG ABUSE, ALCOHOLISM, CONTAGIOUS, COMMUNICABLE OR VENERAL DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (**AIDS**), OR TEST FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (**HIV**). PATIENTS REQUESTING MEDICAL RECORDS WILL BE CHARGED A FEE OF $10.00, AND DOCTORS REQUESTING MEDICAL RECORDS REQUIRE NO FEE.