



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.