Mark Eldore, MD Robin, Fincher, CNM
Kaylie Temporal, PA-C Melissa Garrett, FNP-C
Lauren Crumm, PA-C Dana Kennedy,PNP-C

Obstetrics • Gynecology • Hormone Therapy
Pediatrics • Well Child • Sports Physicals • ADHD Treatment

PLEASE ALLOW 15 BUSINESS DAYS FOR RECORDS TO BE PROCESSED/PRINTED

Authorization to Release Medical Information

Patient Name: ______________________________ Birth Date: ___/___/___
(please print)
Phone #: (   )____-__________ SS# ______-____-______

- o I wish to request my medical records from the doctor listed below to be sent to Athens Women's and Children's Center
- o I wish my medical records to be sent from Athens Women's and Children's Center to the doctor listed below.

Dr. ______________________________
Address: ______________________________
City/State/Zip: ______________________________
Telephone: (   )_____-______________
Fax: (   )______-__________________

- o Entire Medical Records
- o Surgical or Medical Procedures
- o X-rays/Mammo Reports
- o Emergency Room Visits
- o Shot Records
- o Lab Results

Purpose:

- o Physician/Health Care Facility
- o Legal/Attorney
- o Insurance Company
- o Other

- Are you pregnant? ______yes ______no
- Are you transferring your care to another physician? ________ yes ________no
- If so, please explain why: ______________________________

I understand that my expressed consent is required to release any health care information if I have been tested, diagnosed, and/or treated for HIV(AIDS virus), or alcohol use. You are specifically authorized to release all health care information related to such diagnosis, testing or treatment.

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR part 2) prohibits you from making any further disclosure of it without specific written consent of the person to who it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Patient's/Authorized Representative Signature: ______________________________ Date: ________
(This authorization is valid for a period of 180 days)

If records are being requested by the patient or being sent to any other facility other than a healthcare provider, there is a $25-dollar charge for the 1st 20 pages of medical records and .50 cents for any page thereafter. There is no charge for records being sent to another healthcare provider.