Atlanta Gynecology & Obstetrics, P.C.
Records Release (Inbound)

To:

Doctor	
Street/Suite #	
City/State/Zip	
Phone # Fax #	
Patient Name	
Date of Birth (mm/dd/yy)	
Social Security #	

Your patient is requesting records to be sent to our location selected below:

☐ 315 Winn Way
Decatur, GA 30030
Telephone (404) 299-9724
Fax (404) 299-0382

☐ 449 Pleasant Hill Road, Suite 200
Lilburn, GA 30047
Telephone (770) 923-5033
Fax (770) 279-2769

(Check all applicable)

- ☐ All Records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing Records
- ☐ Chart Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically) _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., included herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphllis, VDRL, chanroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes ☐ No ☐ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes ☐ No ☐ I authorize the release of any records regarding drug, alcohol, or mental treatment to the person(s) listed above.

For the purpose of: (Optional)

- ☐ Further Medical Care
- ☐ Insurance Billing
- ☐ Legal Reasons
- ☐ Self
- ☐ Other (Please Specify) _____

Patient Signature: _____ Date: _____