East Georgia Women's Center

Release of Medical Record Authorization Form

1. **Patient Name**:_____

   DOB:_____ SSN:_____

   Telephone #:_____

   Address:_____

2. **Information to include:**

   ___ Full Disclosure of all records ___ All Prenatal Records
   ___ Office Notes ___ Op Reports and Pathology Reports
   ___ Labs ___ Ultrasounds/Radiology Reports
   ___ Other:_____

   **Date range of records requested _____ to _____.

3. **Purpose of Disclosure**

   ___ Personal Copy ___ Transfer of Care ___ Legal Reason
   ___ Other:_____

4. The health information described above may be:

   (Circle one) RELEASE TO or OBTAIN FROM

   _____ East Georgia Womens Center

   George A. Palmer, M.D.

   Phone: 912-871-4800

   Fax: 912-681-1344 or 912-871-4900

   (Circle one) RELEASE TO or OBTAIN FROM

   ____ Practice Name:_____

   Address:_____

   Phone #:_____ Fax:_____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment,or other purposes as I may direct. I understand that I have the right to revoke this authorization, inwriting, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization maybe disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature:_____ Date:_____

OFFICE USE ONLY

Date Request Faxed: _____ Employee Initials:_____
Date Received Records:_____ Employee Initials:_____