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MEDICAL RECORD RELEASE

PATIENT'S NAME: _____ DOB: _____ - _____ - _____

SSN#: _____ - _____ - _____ PHONE: _____ - _____ - _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

I authorize _____
(name of facility or physician to release records)

(city, state, zip) (phone #) - (fax #)

To release information to VALDOSTA WOMEN'S HEALTH CENTER

All Medical Records Specifically/Including _____

REASON FOR TRANSFER _____

I place no limitations, and I understand that the information to be released may refer to history of illness, diagnostic and therapeutic information, including any treatment for alcohol or drug abuse/dependency; psychiatric or psychological addictions; mental illness or retardation; acquired immune deficiency syndrome (AIDS/HIV); and sexually transmitted diseases (STD's). I am aware that there **may** be a processing fee for records released to me, using the formula re-approved 07/01/2006, under O.C.G.A. 31-33-3. This charge includes an administrative fee, a certification fee, a per-page fee, and actual postage charges (if applicable). I also understand that payment for medical records should be directed to **Valdosta Women's Health Center, P.C., P.O. Box 2130, Valdosta, GA, 31604**, and paid at the time the records are released. Your medical records will be available within 3-5 business days. Should you wish to have your medical records sent via mail, you will receive a copy of this signed statement with the amount of the processing fee. The payment of this fee must be received prior to releasing your medical records.

Patient or Guardian Signature

Date

Patient's Printed Name

Witness

FOR OFFICE USE ONLY
Date(s) Faxed: _____
Date Received: _____