Valdosta Women's Health Center

604 East Park Ave ♦ P.O. Box 2130 ♦ Valdosta, GA 31604-2130

♦ 229-333-0277 ♦ FAX 229-241-1608 ♦

Ellen E. Courson, MD ♦ Danielle McFarland, MD ♦ Millie Jordan, NP-C

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** _____

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:_____