ATLANTA
WOMEN'S
MEDICAL CENTER

RELEASE OF MEDICAL RECORDS

I, _____, hereby, authorize the Atlanta Women's Medical Center to use or disclose the following protected health information:
Date(s) of service: today, _____, _____, _____

( ) Ultrasound
( ) Laboratory study(ies)
( ) Surgical report
( ) Surgical pathology
( ) Medical Record - inclusive
( ) Medical Record - specified
( ) Gynecologic record – inclusive
( ) Gynecologic record – specified

Specific instructions:_____

The protected information may be disclosed to:

( ) Self
( ) Medical Office named:_____
( ) Insurance Company named:_____
( ) Other: Specified:_____

This protected health information is being used or disclosed for the following purposes:

( ) Personal use
( ) At patient's request
( ) Medical follow-up with PMD
( ) Insurance claim processing
( ) Other: Specified:_____

This authorization shall be in force and effect until:

( ) Date:_____
( ) The happening of the following event:_____

I understand that, as set forth in the Facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Atlanta Women's Medical Center
235 West Wieuca Road
Atlanta, GA, 30342
ATTN: Privacy Officer

_____ _____
Patient Signature Date
Copy of Identification and Signed Release of Records required before any record released

235 West Wieuca Road
Atlanta, GA 30342
(404) 257-0057
(800) 877-6332
FAX (404) 257-1245