RECORDS RELEASE AUTHORITY

TO:

Name: _____

_____

Fax #: _____

I, _____, hereby request that you release to:

(Print First & Last Name)

ATHENS OBSTETRICS & GYNECOLOGY

Ruth M. Cline, MD Andrew H. Herrin, MD Rachel F. Murthy, MD

Rebecca Fletcher, MD Meredith Bolton, MD Cristina Elstad, MD

740 Prince Avenue, Building 3
Athens, GA 30606
Phone: 706-548-4272 FAX: 706-548-9181

a report of my diagnosis, treatment, prognosis and data pertinent to my treatment during the period from:

_____ to _____

I understand this authorization includes the release of all medical records including Human Immunodeficiency Virus records, Psychiatric, Drug/Alcohol abuse records, Venereal Disease, and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has been previously taken in reliance hereof.

Signature: _____

_____

Address City State Zip

DOB: _____ SSN Last 4 #s: _____ Phone:(____) _____-_____

Signature of Witness: _____

Date: _____