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
Katie Sells, WHNP Sabrina Bevelaqua, WHNP
658 N. Chase Street, Suite 301
Athens, GA 30601
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:_____