MODERN
OBSTETRICS & GYNECOLOGY
of North Atlanta, P.C.

Medical Records Release Request

Patient Information:

Patient Name: _____ Contact Number:_____

DOB: _____/_____/_____ Social Security ID:_____

Home Address: _____

City, Sate and Zip: _____

I, _____ authorize the above listed person/s, firm, or entity(or its agents, representatives or employee) to release for inspection and copying and use, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization or care from date/s of: _____/_____/_____ to _____/_____/_____

To/From: (please circle)

Modern OBGYN of North Atlanta
10692 Medlock Bridge Road, Suite 100aA
Johns Creek, GA 30097
Fax: 404-446-2497
Office: 404-446-2496

To/From: (please circle)

Name:_____
Address:_____
City, State, Zip:_____
Fax:_____

Note: All records requests that come *into* our office either written or verbal will initially be processed by our Medical Records Coordinator. From that point, requested information will be forwarded to the provider for approval and signature. No records are to be released without the provider's approval and Administrative Certification. Please note, there will be a Fee of $35.00 if the records are released ***to you*** directly.

What Records Do You Need:

- ☐ Entire Record
- ☐ Radiology/Xray Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Laboratory Results
- ☐ Labor & Delivery Records
- ☐ ER/Hospital Reports
- ☐ Other: _____

Which Provider Do You See:

- ☐ Dr. John Reyes
- ☐ Dr. Ingrid Reyes
- ☐ Dr. Natu Mmbaga
- ☐ Dr. Annie Kim
- ☐ Dr. Nada Megally
- ☐ Dr. Zin Alonso
- ☐ Emily Dixon
- ☐ Skyler Jacobs
- ☐ Mimi Song
- ☐ Keianna Haley
- ☐ Rebecca Helie
- ☐ Katie Vaughn
- ☐ Diana Cedillo
- ☐ Kristine Raynard
- ☐ Laura Wiese
- ☐ Lana Wertz
- ☐ Kristi Vines-Presley
- ☐ Julie Cox-Morgan
- ☐ Joanne Lee
- ☐ Gisele Cavalheiro
- ☐ Amber Becker
- ☐ Chelsea Robinson
- ☐ Other
- ☐ _____

Reason For Records Request: ☐ Relocation ☐ Insurance Change ☐ Patient Discontent ☐ Second Opinion
☐ Employment Request ☐ Other: _____

Patient Signature of Release: _____ Date: _____/_____/_____

_____Initials of Certifier

_____ Date Completed/Sent/Mailed