



Medical Records Release Request

Patient Information:

Patient Name: _____ Contact Number: _____
 DOB: ____/____/____ Social Security ID: _____
 Home Address: _____
 City, State 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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Dr. John Reyes | <input type="checkbox"/> Emily Dixon | <input type="checkbox"/> Kristi Vines-Presley |
| <input type="checkbox"/> Dr. Ingrid Reyes | <input type="checkbox"/> Skyler Jacobs | <input type="checkbox"/> Julie Cox-Morgan |
| <input type="checkbox"/> Dr. Natu Mmbaga | <input type="checkbox"/> Mimi Song | <input type="checkbox"/> Joanne Lee |
| <input type="checkbox"/> Dr. Annie Kim | <input type="checkbox"/> Keianna Haley | <input type="checkbox"/> Gisele Cavalheiro |
| <input type="checkbox"/> Dr. Nada Megally | <input type="checkbox"/> Rebecca Helie | <input type="checkbox"/> Amber Becker |
| <input type="checkbox"/> Dr. Zin Alonso | <input type="checkbox"/> Katie Vaughn | <input type="checkbox"/> Hemali Patel |
| <input type="checkbox"/> Dr. Tina Lu | <input type="checkbox"/> Lana Wertz | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dr. Natalie Clericuzio | <input type="checkbox"/> Kristine Raynard | |
| <input type="checkbox"/> Dr. Miranda Long | <input type="checkbox"/> Laura Wiese | |

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