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 ______/_____/_____

<u>To/From:</u>
Modern Obgyn of North Atlanta
10692 Medlock Bridge Road, Suite 100-A
Johns Creek Ga 30097
Fax: 404-446-2497
Office: 404-446-2496

<u>To / From</u>:
Name:_________________________________
Address:______________________________
City, State, Zip:_______________________
Fax:__________________________________

<u>Note</u>: 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. Stacey Pereira
- ☐ Dr. Christy Kenkel
- ☐ Dr. Nada Megally
- ☐ Nuria Nelkin
- ☐ Emily Dixon
- ☐ Melanie Steen
- ☐ Cecelia Brown
- ☐ Mimi Song
- ☐ Keianna Haley
- ☐ Skyler Jacobs
- ☐ Kristi Vines-Presley
- ☐ Julie Cox-Morgan
- ☐ Joanne Lee

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

Revised 03/2021