COVINGTON WOMEN'S HEALTH SPECIALISTS
4181 Hospital Dr. NE. Suite 101 & 104, Covington, GA 30014
5154 Cook Street NE, Covington, GA 30014
PHONE: 770-385-8954 FAX: 770-385-8590

Medical Records Request

Authorization For Use/Disclosure of Protected Health Information

PATIENT INFORMATION:

Patient's Full Name: _____

Date of Birth: _____ Last four (4) digits of your Social Security Number: _____

Maiden/other Name: _____ Current Address: _____

Patient's Phone Number: _____ Alternate Phone Number: _____

REQUEST AUTHORIZATION:

I hereby request and authorize Covington Women's Health Specialists to **RECEIVE MY RECORDS FROM:**

_____
NAME AND ADDRESS OF DOCTOR OR HOSPITAL

_____ _____
PHONE NUMBER FAX NUMBER

RECORDS NEEDED: _____

I hereby request and authorize Covington Women's Health Specialists to **SEND MY RECORDS TO:**

_____
NAME AND ADDRESS OF DOCTOR OR HOSPITAL

_____ _____
PHONE NUMBER FAX NUMBER

For the following types of information from my records (and any specific portion thereof):

( ) Completing requested Consultation
( ) Transfer of Care
( ) Other _____

REASON FOR TRANSFER: _____

I understand this authorization included release of all medical records including HIV results, records of psychiatric evaluation, drug of alcohol abuse treatment records 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 to the extent that action has previously been taken in reliance thereof.

_____ _____
Patient or Person Authorized to consent for patient Date

_____ _____
Relationship to Patient Witness