



REQUEST FOR MEDICAL RECORDS

I, _____, hereby request and authorize

_____ to release all or any part of my medical records including information or treatment for AIDS/HIV infection, communicable or venereal diseases, psychiatric impairments, drug abuse or alcoholism.

I hereby request and authorize my records be released to:

Genesis Women's Care
 185 Professional Ct. Suite 1
 Calhoun, GA 30701

Requesting the following:

- Pap Smears Operative Reports Diagrams Biopsy Reports
- Discharge Summaries Histories & Physicals X-rays & Ultrasounds
- Path & Lab Reports Prenatal Records w/lab copies All records

Patient Soc Sec #: _____

Date of Birth: _____

Guardian
 Signature: _____

Date: _____

Relationship to Patient: _____

Witness: _____

Date: _____