# SAVANNAH OB/GYN, PC


**Heart & Lung Building**
**5356 Reynolds Street, Suite 410**
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OBTAIN MEDICAL RECORDS

TO: ______________________________

Fax # ______________________________

Address: ______________________________

______________________________

RE: Patient's Name ______________________________

Date of Birth ______________________________

SSN # ______________________________

Patient's Address ______________________________

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I request that all my medical records be released to the following:

**Savannah OB/GYN, P.C.**
5356 Reynolds Street, Suite 410 • 5353 Reynolds Street, Suite 300
Savannah, GA 31405

I place no limitation on history or illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, HIV test, or psychiatric disorders.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

______________________ ______________________________

Date Signature of Patient (or guardian)

______________________________

Relation to Patient (if applicable)