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MEDICAL RECORDS RELEASE

Patient's Name ____________________

Date of Birth ____________________

SSN# ____________________

Patient's Address ____________________

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I hereby authorize Savannah OB/GYN P.C. to release my medical records to the following physician:

Name ____________________

Address ____________________

____

Phone# ____________ Fax # ____________

I place no limitation on history of 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 ____________________
Relation to Patient ____________________