

SAVANNAH OB/GYN, PC

Heart & Lung Building
5356 Reynolds Street, Suite 410
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Lawrence N. Odom, M.D.
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OBTAIN MEDICAL RECORDS

TO: _____
Fax # _____
Address: _____

RE: Patient's Name _____
Date of Birth _____
SSN # _____
Patient's Address _____

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)