809 Cleveland Ave S.W.
Atlanta, GA 30315
404-767-2536 / Voice
www.cwhallc.com

THIS FORM MUST BE FILLED OUT COMPLETELY IN ORDER TO FULFILL YOUR REQUEST

Patient Name: _____ **DOB:** _____ **SSN:** _____

Address: _____ **Phone:** _____

Print name of Parent/Guardian (if request is for a minor):_____

Information Requested:

( ) Progress Notes **( ) Surgical notes** **( ) All records on file**
( ) Lab &/or Radiology Tests **( ) Hearing / Audio Exams**
( ) Other: _____

I hereby request and authorize that the physician/practice listed below furnish these records to :

Comprehensive Women's Healthcare Atlanta LLC; 809 Cleveland Ave S.W., Atlanta, GA 30315
Phone: 404-767-2536 Fax: 404-767-2779

Provider: _____

Practice: _____

Address: _____

Phone: _____ **Fax:** _____

I understand that all information I hereby authorized to be obtained/released will be held in the strictest confidence and cannot be released without my written consent. I understand that this authorization will remain in effect for up to one year from this date.

I understand that unless otherwise limited by state or federal regulations, an except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Date: _____ **Signature of Client/Guardian:**_____

Date: _____ **Signature of Witness:** _____

Please allow at least 1-2 weeks for medical records to be prepared as some of the materials you have requested may be in storage. We appreciate your patience in this manner. If you have any questions please do not hesitate to contact our office at 404-767-2536 or from our website at www.cwhallc.com

I prefer to have these records:

___ Mailed ___ Faxed ___ E-Mailed ___ I will pick them up when notified they are ready