



REQUEST FOR MEDICAL RECORDS
FROM GWINNETT'S PROGRESSIVE HEALTHCARE FOR WOMEN

Name: Last First Middle Maiden Date of birth:

Address: Street Apt #/Suite City State Zip Code

Home #: Work #: Cell #: Email Address:

I do hereby authorize: Gwinnett's Progressive Healthcare for Women Phone #: 770-339-4000 | Fax #: 770-339-9037
To Release: Specific dates

- Entire record
Pap Smear
Mammogram
Bone Density
Office notes
Lab reports
Pathology
Hospital records
Operative notes
Other:

IMPORTANT: PLEASE READ
I understand that this health information may include AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, sexually transmitted diseases, genetic testing, psychiatric care and/or psychological assessment and/or treatment for alcohol and/or drug abuse.

Send Records to:

ATTENTION: Phone: Fax:

Address: Street Apt #/Suite City State Zip Code

- Purpose of disclosure:
Referral to specialist
PCP
Change of provider
Personal
Insurance
Disability
Worker's compensation
Legal
Other:

I do hereby authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of the signature. I understand that I may cancel this request with a written notification, but it will not affect any information released prior to cancellation.

Signature of Patient or Authorized Person Date

Witness Date