

THE WOMEN'S GROUP OF GWINNETT, P.C.
Records Release Form

I hereby authorize and request The Women's Group of Gwinnett to release any information regarding the diagnosis, examination and treatment rendered by TWGG or any other physician consulted by TWGG to the following:

Initial pertinent categories below authorizing consent:

- All records pertaining to my medical care
- Any records regarding HIV may be released
- Any records regarding alcohol or drug use may be released
- Any records regarding psychological or psychiatric treatment may be released
- Specific requests:

Reason: _____
Request will expire 30 days from date signed.

PRINTED NAME _____

SS# _____

DOB: _____

SIGNATURE: _____

DATE: _____

WITNESS: _____

THE WOMEN'S GROUP OF GWINNETT, P.C.
Records Release Form

To: _____

I, hereby, request the release of any information regarding the diagnosis, examination and treatment rendered by you or any other physician consulted by you to the following:

The Women's Group of Gwinnett, P.C. 1700 Tree Lane Rd, Suite 230 Snellville, GA 30078 Fax: 770-979-1060
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Initial pertinent categories below authorizing consent:

- _____ All records pertaining to my medical care
- _____ Any records regarding HIV may be released
- _____ Any records regarding alcohol or drug use may be released
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