Alison Wright, MD Tan-Loc Nguyen, MD David Quang DO
Chinenye Adimora-Okolie, MD Ashley Williams-Hernandez, MD Julie Conway, NP-C Candace Gates, NP-C
Allison Griffin, NP-C Jessica Austel, PA Barbara Orange, NP-C Melanie Adams, NP-C
Jennifer Smith, CNM Stacey Stout, CNM Lindsey Kyte, CNM Samantha Fruge, CNM

Medical Records Release Form

I, _____ authorize Women's Healthcare, P.C. to release my medical records to the following physician or facility:

Name/Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

I, _____ authorize the following physician/facility to release my medical records to Women's Healthcare, P.C.:

From: _____

Address: _____

_____

Phone: _____Fax: _____

I hereby authorize the release of all my medical and surgical records. This information is to include, but not limited to, medical information, mental health information, personal habits, alcohol use, drug use, and HIV status, if applicable.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Reason for disclosure: ____ Change of Insurance _____ Moving Out of Area _____Transfer of Care
_____Personal _____Legal _____Continuation of Care ____ Consultation

Please send: ____ Office Notes____ Lab Reports ____Complete Record ____Xray/Imaging
____Other (Specify _____)

Patient Signature: _____ Date: _____

Date of Birth: _____ SS# _____

Patient Telephone Number: _____

130 Byrd Way Warner Robins, GA 31088
(Ph) 478-922-9136 (Fax) 478-923-6846

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