Evans Gynecology
465 N. Belair Rd, Suite 2-E, Evans GA 30809
706-855-5510 ~ 706-855-7254 (fax)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To Dr.________________________________ Date: __________

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Name: __________________________ DOB: _________SSN#: _______________

Address: ____

City, State, Zip: ____

Telephone: _______________________

I, _________________________, hereby request that you release a **complete** copy of
(print name as it appears on medical records) my medical records to:

Dr. Niti Bhalla Carlson
Evans Gynecology
465 N. Belair Rd, Suite 2-E
Evans, GA 30809
706-855-5510 ~ 706-855-7254 (fax)

Authorization:
I understand that the information may contain testing or treatment information relating to mental health, drug and/or alcohol abuse treatment, sexually transmitted diseases and/or HIV/AIDS. **I understand** that once this information is disclosed it is subject to redisclosure and it may no longer be protected by the federal privacy regulation. **I understand** that this form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Health Information Department. **I understand** that refusal to sign this authorization does not condition treatment. **I understand** that this authorization will expire sixty (60) days from the date signed unless other specified.
Authorization expires: ________________.

Signature: ______________________________ Date: ___________________

Relationship to patient, if not patient: ___________________

Witness: _______________________________ Date: ___________________

Federal and state laws permit a fee to be charged for the copying a patient records. Fees are required before copies are released.