

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Home Number/Cell Number: _____

I authorize:

DeKalb Women's Specialists

To release my medical records to:

Physician/Practice: _____

Address: _____

Home Number/Cell Number: _____

Fax: _____

Date of Request

Patient Signature

Please send completed form to: frontdesk@dekalbwomen.com

IMPORTANT NOTE: *This Authorization Form is valid for one year only.*