Marietta OB-GYN Affiliates, P. A.

699 Church Street, Suite 220, Marietta, GA 30060

phone 770.422.8505 fax 770.693.7387 or 844.289.8257

Date ______________________

Patient Name (print) ____ DOB ____________________

Patient Phone number _____________________________________

I hereby authorize Marietta OB-GYN Affiliates, P.A. to (choose one of the following):

☐ Release records to ☐ Receive records from

Practice/Doctor's Name: ____

Address: ____

____

Phone: ___________________________________

Fax: ___________________________________

Information requested:

- ☐ Most Recent Information
- ☐ Entire Chart
- ☐ Other (specify) ____

Purpose of request:

- ☐ Patient request
- ☐ Transfer of care Are you leaving the practice? _____ Should we cancel any appointments? ______
  If yes, reason: ____
- ☐ Other ____

This authorization will expire:

☐ One year from date of signature ☐ no expiration date

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire according to option chosen above.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature: ____ Date: ________________________

**If signed by someone other than patient, legal relationship: _____________________________________

Witness: ___________________________ Date: _____________