**Gyn Assoc of N. GA**
2450 Atlanta Hwy Building 100, Ste 103 Cumming, GA 30040-8099
(770) 887-0559 Fax:



## Release of records from

gynecology associates
OF NORTH GEORGIA

Patient:
DOB:
Patient Contact Number:(_____)_____

I hearby request Gynecology Associates of North Georgia to release my medical records to:

Recipient:_____

Address: _____

_____

_____

Fax: _____

Please include the following:

___History & Physical
___Operative Report
___Pathology Report
___Lab Results
___All of the above
___X-Ray Report
___Discharge Summary
___Consultation Notes

Please be aware that the processing of medical records may take 7-10 business days to complete.

Patient Signature _____ Date_____