THE WOMEN'S GROUP OF GWINNETT, P.C.
Records Release Form

I hereby authorize and request The Women's Group of Gwinnett to release any information regarding the diagnosis, examination and treatment rendered by TWGG or any other physician consulted by TWGG to the following:

Initial pertinent categories below authorizing consent:

_____ All records pertaining to my medical care
_____ Any records regarding HIV may be released
_____ Any records regarding alcohol or drug use may be released
_____ Any records regarding psychological or psychiatric treatment may be released
_____ Specific requests:

____

____

____

Reason: ____
Request will expire 30 days from date signed.

PRINTED NAME ____

SS#__________________________________

DOB:____________________________

SIGNATURE:____

DATE:________________________________

WITNESS:____

THE WOMEN'S GROUP OF GWINNETT, P.C.
Records Release Form

To:

I, hereby, request the release of any information regarding the diagnosis, examination and treatment rendered by you or any other physician consulted by you to the following:

The Women's Group of Gwinnett, P.C.
500 Medical Center Blvd Suite 250
Lawrenceville, GA 30046
Fax: 770-979-1060

Initial pertinent categories below authorizing consent:

_____ All records pertaining to my medical care
_____ Any records regarding HIV may be released
_____ Any records regarding alcohol or drug use may be released
_____ Any records regarding psychological or psychiatric treatment may be released
_____ Specific requests:

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Reason: ____
Request will expire 30 days from date signed.

PRINTED NAME ____

SS#__________________________________

DOB:____________________________

SIGNATURE:____

DATE:________________________________

WITNESS:____