Patient Records Request Form
Women's Health Group
3300 Fourth Street
Brunswick, Georgia 31520
912-267-0884
Fax 912-267-0254

Full Name:________________________________SS#__________________

DOB:___________Phone:____________________Cell:_________________

Address____

Please release my records to:

____
____
____

Please obtain my records from: ___________________________________
____
____

Please provide a copy of the record as indicated below:

- ☐ The full health record maintained by this provider/practice.
- ☐ The health record from dates _________through_________.
- ☐ A specific section of the health record as described below:

____
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- ☐ A summary of the information requested above is adequate to fulfill this request.

*As permitted by Federal and State law, I understand that a fee will be charged for copying the records along with a clerical fee. I agree to pay this charge in full at the time I receive the copy of the record.

This authorization shall expire on ___________. After this date, Women's Health Group of Southeast Georgia can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

Signature of Patient ________________________________Date____________

Signature of Representative __________________________Date____________