

ATHENS HEALTHCARE FOR WOMEN, P.C.
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Athens, GA 30606
(706) 552-1600
(706) 552-5370 Fax

Request for Records/Release of information

Patient Name: _____

Address: _____

Date of birth: _____ Social Security #: _____

____ I authorize the physician/facility listed below to release my records to Athens Healthcare for Women

____ I authorize Athens Healthcare for Women to release my records to the physician/facility listed below.

Physician/Facility name: _____

Address: _____

City, State, Zip Code: _____

Phone/Fax #: _____

I understand this authorization includes release of all medical records and protected health information.

Signature of patient or authorized patient representative

Date

Witness

Date