Tina Mitchell, MD, FACOG

7000 Wellness Way . Suite 7220 . St. Simons . Georgia 31522
t 912.638.1801 f 912.638.1821

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records pertaining to:

- All medical treatment From (date)_____ To (date)_____
- Laboratory tests
- Specific treatment

The purpose for requesting my medical records: _____

I understand that my records may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus). Also, any reference of psychiatric care, treatment for alcohol and/or drug abuse that may be in my medical record.

These records are to be released to:

_____ _____
Name Address

_____
City, State, Zip

There is a $20.00 charge for copying medical records. There is no charge for single copies of test results. We do not copy records that have been sent to us by another Physician or Health Care Provider.

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.

_____ DOB _____
Print Patient Name

_____ Date: _____
Patient Signature

Witness: _____

Usually the copied chart is sent out 5-7 business days after the request is received. If you plan to pick up your chart, we will call you when the chart is ready to be picked up.