Tina Mitchell, MD, FACOG

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MEDICAL RECORDS REQUEST

To: Dr. _____

Address: _____

_____

_____

Tele: _____- _____ - _____ Fax: _____- _____ - _____

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

The purpose for requesting my medical records: _____

I hereby authorize the release of my medical records of copies of such and request that they are transferred to:

Lily Obstetrics and Gynecology, LLC
Tina Mitchell, M.D.
7000 Wellness Way, Suite 7220
Saint Simons Island, GA 31522
Tel: 912-638-1801
Fax: 912-638-1821

Patient name: _____ Date: _____

Patient DOB: _____

Date of Records: From: ___ / ____ / ____ to ___ / ____ / _____

Patient signature: _____