



Obstetrics & Gynecology of Atlanta

Ob/Gyn
 Thomas E. Sharon, M.D.
 Kirsten L. Franklin, M.D.
 Genevieve L. Fairbrother, M.D.
 Charles D. Wooten, M.D.
 Claire A. Parker, M.D.
 Keisha N. Dennard-Hall, M.D.
 Jill J. Henke, M.D.
 Christopher E. Bassil, M.D.

Nurse Practitioners
 Dianne McMullen, CFNP

Nurse Midwives
 Dixie Shepard, CNM
 Libby Edwards, CNM
 Mitra Mansouri- Davis, CNM
 Kelley Starnes, CNM
 Christine Gordon, CNM

Authorization to Release Medical Information

Phone 404-252-1137 Fax 404-506-9221

Patient Name (Print): _____

Current Address: _____

Home #: _____ Cell #: _____ Date of Birth: _____

Who has the information you would like released?

Dr. Name: _____ Business Name: _____

Address: _____ Ste. # _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

To Whom should the information be sent?

Name: _____ Business Name: _____

Address: _____ Ste. # _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Reason for Request:

Selected new physician in the area | Second opinion / Consult | Change of Insurance | Moving out of town
 Other _____

Portion of records to be released:

Entire medical record | Other (describe in detail) _____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the express purpose identified above, unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Notice: Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnoses, treatments, assessments, recommendations for further care, names of all health care personnel, dates of hospitalization and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and /or sexually transmitted diseases, including HIV/AIDS information. By signing this form I acknowledge and understand there may be a charge for the administration and copying of my medical records.

Exclusions (Please initial):

_____ Drug / Alcohol _____ Mental Health / Psychiatric _____ Sexually Transmitted Disease _____ HIV / AIDS

This authorization is valid for one year or until _____, whichever comes first.

Patient Signature: _____ Date: _____

A Photocopy of this release is as valid as the original

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.

Northside • 975 Johnson Ferry Road, N.E. • Suite 400 • Atlanta, Georgia 30342 • (404) 252-1137
East Cobb • 1519 Johnson Ferry Road • Suite 175 • Marietta, Georgia 30062 • (770) 565-2233
Johns Creek • 3890 Johns Creek Parkway • Suite 300 • Suwanee, Georgia 30024 • (678) 775-2300