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Annie Kim, M.D., F.A.C.O.G.
Stacey Pereira, M.D.

Medical Records Release Request

Patient Information:

Patient Name: _____
DOB: ____/____/_____
Home Address: _____
City, State and Zip: _____

Contact Number: _____
Social Security ID: _____

I, _____ authorize the above listed person/s, firm, or entity (or its agents, representatives or employee) to release for inspection and copying and use, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization or care from date/s of: ____/____/____ to ____/____/____

To/From:

Modern Ob/Gyn of North Atlanta
10692 Medlock Bridge Road, Suite 100-A
Johns Creek Ga 30097
Fax: 404-446-2497
Office: 404-446-2480

To/From:

Name: _____
Address: _____
City, State, Zip: _____
Fax: _____

Note: All records requests that come *into* our office either written or verbal will initially be processed by our Medical Records Coordinator. From that point, requested information will be forwarded to the provider for approval and signature. No records are to be released without the provider's approval, and Administrative Certification. Please note, there will be a Fee of \$35.00 if the records are released **to you** directly.

What Records Do You Need:

- Entire Record
- Radiology/X-ray Reports
- Operative Reports
- Pathology Reports
- Laboratory Results
- Labor & Delivery Records
- ER/Hospital Reports
- Other: _____

Which Provider Do You See:

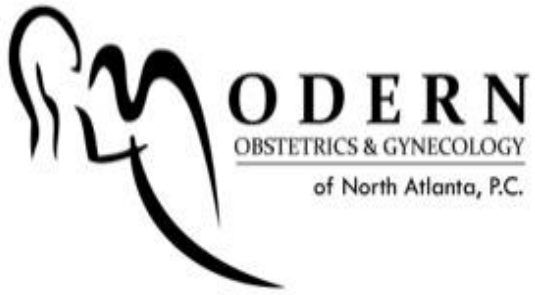
- Dr. John Reyes
- Dr. Ingrid Reyes
- Dr. Natu Mmbaga
- Dr. Annie Kim
- Dr. Stacey Pereira

Reason For Records Request: Relocation Insurance Change Patient Discontent
 Second Opinion Employment Request Other: _____

Patient Signature Of Release: _____ Date: ____/____/_____

Initials of Certifier

Date Completed/Sent/Mailed



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