# Evans Gynecology, LLC

465 N. Belair Rd, Suite 2-E, Evans GA 30809
706-855-5510 ~ 706-855-7254 (fax)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To Dr._____ Date: _____

_____

_____

_____

Name:_____DOB:_____SSN#: _____

Address: _____

City, State, Zip:_____

Telephone:_____

I _____, hereby request that you release a **complete** copy of
(print name as it appears on medical records) **my medical records to:**

Dr. Niti Bhalla Carlson
Evans Gynecology, LLC
465 N. Belair Rd, Suite 2-E
Evans, GA 30809
706-855-5510 ~ 706-855-7254 (fax)

Authorization:
I understand that the information may contain testing or treatment information relating to mental health, drug and/or alcohol abuse treatment, sexually transmitted diseases and/or HIV/AIDS. I understand that once this information is disclosed it is subject to redisclosure and it may no longer be protected by the federal privacy regulation. I understand that this form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Health Information Department. I understand that refusal to sign this authorization does not condition treatment. I understand that this authorization will expire sixty (60) days from the date signed unless other specified.
Authorization expires:_____

Signature:_____Date:_____

Relationship to patient, if not patient:_____

Witness:_____Date:_____

*Federal and state laws permit a fee to be charged for the copying a patient records. Fees are requred before copies are released.*