PREMIER CARE FOR WOMEN, P.C.

"Health Care For Women By Women"
Gynecology, Menopause & Urogynecology
Board Certified

Eva S. Arkin, M.D. Laura W. Cummings, M.D. Sujatha Reddy, M.D.
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TO: PREMIER CARE FOR WOMEN - Fax 404-851-9894

Please release the items noted below from my medical record:

____ Last visit ____ Previous 1 calendar year ____ Previous 3 calendar years
____ Current year ____ Previous 2 calendar years ____ Other (please list specific requests below)

____

____

PLEASE SEND MY RECORDS ON: PAPER CD (CIRCLE ONE)

Please provide these records to: ____

Address ____

____

Fax# ____

*CDs only mailed to patient's home address

* Please allow 3 – 5 business days to process request

I understand this authorization will include any medical records including HIV records, psychiatric or drug or alcohol abuse records, venereal disease and/or any other statutory protected diseases. This authorization and consent will expire 60 days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

I understand that a fee for copying medical records may be incurred. Charges will not exceed the allowable fees as set forth by the State of Georgia. To speed up your process, please tell us how to provide you with your quotation:

_____ Call me with my quotation at this phone number (with area code) ___________________________

______ Mail my quotation to me at the address listed below.

______________________________ Patient Address: ____________________________

Patient Signature ____________________________

______________________________ ____________________________

Print Name

Phone # ______________________

(if different from above)

______/________/________

Date of Birth

____

Today's Date

xxx -- xx -- _________

last 4 digits Social Security Number

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