SHAW CENTER FOR WOMEN'S HEALTH, PA

Obstetrics, Gynecology and Midwifery

918 South Broad Street • Thomasville, GA 31792

Telephone (229) 226-8800 Fax (229) 226-8232

I, _____, Social Security Number: _____ and

Date of birth: _____ hereby request that _____

_____ release the following indicated information to the following person.

Name: _____

Address: _____

_____

_____ Pap Smear Date of: _____

_____ Labs Only Date of: _____

_____ History and Physical Forms Date of: _____

_____ Ultrasound and X-Ray Reports Date of: _____

_____ All Medical Records Date of: _____

_____ Other: _____ Date of: _____

Reason for Release:

_____

_____

CAREFULLY READ THE FOLLOWING:

I am aware that some of the information in the requested medical records may be of a sensitive nature. By signing below, I am granting permission for information pertaining to the above-mentioned areas to be released. I waive any privilege or confidentiality existing under Federal or State law regarding such information, including, but not limited to, protection afforded to:

- ❑ Communications made to a psychiatrist (O.C.G.A. S24-9-21)
- ❑ Communications made to a Licensed Applied Psychologist (O.C.G.A. S43-36-16)
- ❑ Medical information concerning alcohol and drug dependency (O.C.G.A. S37-1-166)
- ❑ Medical information regarding mental illness.
- ❑ Medical information concerning mental retardation (O.C.G.A. S37-4-125)
- ❑ Medical information concerning alcohol and drug abuse (42 C.F.R. Part 2)
- ❑ HIV and AIDS confidential information (S31-22-9.1 and S24-9-47)

By signing this form you are releasing the above listed organization/physician from legal ramifications for sending this information to the Shaw Center for Women's Health, P.A.

SIGNATURE: _____ Date: _____

RELATIONSHIP TO PATIENT: _____This authorization and consent is in effect for 90 days. The authorization will terminate 90 days from the date appearing below. **THIS FORM MUST BE WITNESSED.** You have the right to revoke this form by sending us a signed statement to that effect.

Witness: _____ Date: _____