REQUEST FOR MEDICAL RECORDS

Authorization to Release Medical Records to Advanced Gynecology Specialists of Augusta

To Dr : _____ Date _____

_____

_____

_____

(Please print your name as it appears on medical records)

I, _____ hereby request that you release a complete copy of my medical records to:

Dr. Paul M. Thaxton
Advanced Gynecology Specialists of Augusta
7013 Evans Town Center Blvd. Suite 101
Evans, GA 30809
706-922-4545

FAX: 866-777-2246

Patient Signature _____ Date of Birth _____

Patient Address _____

City, State, Zip _____

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