Shaw Center for Women's Health P.A.
918 S. Broad St.
Thomasville, GA 31792
P: 229-226-8800
F: 229-226-8232

Shaw Living
2484 E. Pinetree Blvd.
Thomasville, GA 31792
P: 229-226-8800
F: 229-226-8232

I, _____, Social Security Number: _____ and

Date of birth _____, Phone # _____

hereby request that: Name of Physician or Office records are coming from _____

Phone #: _____ **Fax #:** _____ **City & State:** _____

release the following indicated information to the following person: Name of Physician/Facility/Person records are going to _____

_____

Phone #: _____ **Fax #:** _____ **City & State:** _____

☐	Pap Smear	Date:	
☐	Labs Only	Date:	
☐	History and Physical Forms	Date:	
☐	Ultrasound, X-ray and Mammogram Reports	Date:	
☐	All Medical Records	Date:	
☐	Other	Date:	

Reason for Release: (Circle One)
☐ Transferring Care ☐ Personal ☐ Moving ☐ Legal
Other (Please List) _____

ARE YOU PREGNANT? ☐ **YES** **or** ☐ **NO**

PLEASE NOTE: RECORDS CONTAINING MORE THAN 10 PAGES WILL BE SENT ON A DISK.

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 or from 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: _____