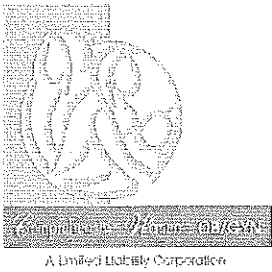


Comprehensive Women's OB/GYN



11 Dunwoody Park
Suite 100
Atlanta, GA 30338
Telephone (770) 730-0451

3630 Savannah Place Drive
Building 100, Suite B
Duluth, GA 30096
Telephone (678)474-0203

Authorization to Release Records to Comprehensive Women's OB/GYN

I hereby authorize and request that you release a copy of my medical records covering the period from ____/____/____ to ____/____/____ to Dr. _____ at

**11 Dunwoody Park
Suite 100
Dunwoody, GA 30338
Phone: (770) 730-0451
Fax: (770) 730-0141**

**3630 Savannah Place Drive
Building 100, Suite B
Duluth, GA 30096
Phone: (678)474-0203
Fax: (678)474-0207**

Name: _____ Maiden Name _____

Address _____

Social Security # _____

Date of Birth: ____/____/____

I understand this authorization includes release of ALL medical records including HIV records, psychiatric mental illness, drug/alcohol abuse records, venereal disease and 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.

Signature _____ Date _____

Requesting Records From: _____

Address: _____

Phone: _____

Fax: _____