4151 HOLIDAY STREET, N.W. – CANTON, OHIO 44718 – TELEPHONE (330) 492-8001
FAX (330) 492-2080 – WWW.ATRIUMOBGYN.COM

Medical Records Consent Transfer

Date: _____

Physician Name: _____

Physician Address: _____

_____

Physician Phone Number: _____

Physician Fax Number: _____

Medical records may contain hospital records and/or information regarding sexually transmitted infections (STI's) including HIV/AIDS; alcohol and/or other drug use; or physical abuse. For that reason, please be specific about the information you wish to have released.

_____ Medical history and physical examination
_____ Mammography films and report
_____ Laboratory data
_____ Operative Report
_____ Pathology Report
_____ Summary of obstetrical care
_____ Summary of hospital stay
_____ Entire medical record
_____Ultrasound films and reports

Please forward a summary of my records to **Atrium OB/Gyn, Inc.** with special attention to the areas marked above. Thank you for your attention to this request.

Permission is hereby granted for the release of medical data on my case to the above named physician.

Printed Name_____ **Date of Birth** _____

Social Security Number (last four digits only) _XXX-XX-_____

Signature _____ **Date** _____