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

Medical Records Consent Transfer

Date:

Dear Doctor:

Please forward a summary of my records to Atrium OB/GYN INC. with special attention to the areas marked below. Thank you for you attention to this request.

_____ 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

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

Printed Name_____

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

Date of Birth_____

Signature _____