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

Medical Records Consent Transfer

Date: _____

Provider Name: _____

Provider Address: _____

_____

Provider Phone Number: _____ Provider 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 reports
_____ 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 my medical records to Atrium OB/Gyn, Inc.

Patient Name_____ Date of Birth _____

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

Patient Signature _____ Date _____

☐ **Per Patient Phone Call – Records are needed prior to appointment.**

Atrium Employee Signature: _____ Date: _____