

**CENTER FOR ENDOMETRIOSIS CARE
MEDICAL RECORDS RELEASE AUTHORIZATION**

To request release of your medical records and information FROM the CEC, please complete and sign this form and return it with your fee [if applicable] to:

CENTER FOR ENDOMETRIOSIS CARE
PERIMETER TOWN CENTER
1140 HAMMOND DRIVE
BLDG F, SUITE 6220
ATLANTA, GEORGIA 30328
Fax: 770-913-0005

If you need help completing this form, please contact us at 770-913-0001.

Patient Information			
Patient Last Name		First Name	
Street Address			Apt#
City	State	Zip	
Social Security #		Home Telephone ()	
Date of Birth		Alternate Telephone ()	
<i>The Center for Endometriosis Care has my permission to release information contained in the Medical Record of the above named patient. _____ (please initial)</i>			
Information Requested (please be specific and enter date of service if known):			
Restrictions and/or Exclusions (if any):			
Purpose of Release:			
The Center for Endometriosis Care will provide the information as requested above to the following party (if patient is the intended recipient, please indicate "self"):			
Name			
Attention of		Telephone	Fax
Street Address		Suite/Room	
City	State	Zip	
Name of person completing this form and relationship, if other than patient:			

I hereby authorize the Center for Endometriosis Care (CEC) to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that the CEC cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at the CEC may or may not protect this information once it has been disclosed to the recipient. **Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date.** I understand that I cancel this authorization in writing at any time, except to the extent that the CEC has relied upon it for the purposes stated above. I further understand that if I cancel this request after the CEC has already sent the requested records, the CEC will not retrieve those records.

SIGNATURE OF PATIENT: _____

DATE: _____

Signature of Parent or Guardian (if minor patient): _____

DATE: _____

Relationship to Patient: _____