



THE CENTER FOR ENDOMETRIOSIS CARE
Robert B. Albee, Jr., MD, FACOG, AAGL, ACGE
Ken R. Sinervo, MD, MSc, FRCSC, AAGL, ACGE
PERIMETER TOWN CENTER
1140 HAMMOND DRIVE
BLDG F, SUITE 6220
ATLANTA, GEORGIA 30328

MEDICAL RECORDS RELEASE REQUEST

Dear Healthcare Professional: Robert B. Albee, Jr., MD, FACOG, AAGL, ACGE and/or Ken R. Sinervo, MD, MSc, FRCSC, AAGL, ACGE respectfully request the release of information in the record(s) of your following patient:

Patient Information		
Patient Last Name		First Name
Street Address		Apt#
City	State	Zip
Date of Birth		Home Telephone
Email -		Alternate Telephone
<i>The Center for Endometriosis Care respectfully requests the release of information contained in the Medical Record of the above-named patient. _____ (please initial)</i>		
Information Requested: Any and all office records for the past one (1) year and/or recent pelvic surgery findings, pathology, operative notes, photos as applicable, etc. as related to the diagnosis of Endometriosis and/or chronic pelvic pain, or the potential diagnosis thereof.		
Restrictions and/or Exclusions (if any): Excludes CT, MRI and U/S <u>films</u> . Please include <u>FINDINGS</u> of any such diagnostic tests <u>only</u> .		
Purpose of Release: Free consult/second opinion service by specialty Endometriosis treatment center.		
Documents may be sent to:		
THE CENTER FOR ENDOMETRIOSIS CARE PERIMETER TOWN CENTER 1140 HAMMOND DRIVE BLDG F, SUITE 6220 ATLANTA, GEORGIA 30328 FAX 770-913-0005		
Name of person completing this form and relationship, if other than patient: Heather C. Guidone, Surgical Program Director Center for Endometriosis Care Phone 866-733-5540		

DATE: _____, 20____

We greatly appreciate your courtesy and support on behalf of your above-named patient.