REQUESTED RECORDS

TO: Women for Women, PC
Dr. Felecia L. Dawson
P.O Box 7608
Atlanta, GA 30357-0608
(770)648-4956
Womenforwomen2@gmail.com

I ____ hereby authorize and request you to release my Medical Records to:

Doctor OR Hospital: ____

Street Address: ____

City:___________________________ State: _______________ Zip: _______________

Telephone # ____________________________ Fax# __________________________

Due to The Health Insurance Portability and Accountability Act (HIPAA) and Georgia State laws, Dr. Dawson must maintain and make available to you, her medical records for 10 years. These laws allow a fee to be charged to cover the expenses and labor costs needed to comply with these requirements.

Medical Records Retrieval and Coping Rates for State of Georgia according to Department of Community Health as of July 1, 2016 is $0.97 per page. You can call GA DCH if you have any question regarding current rates at 404-656-4496.

Credit Card # _________________________________ Exp Date: _________________

CVV # ______________ Billing Zip Code: _______________

Check Amount $______________ (please mail this request with your check)

I understand that the charge for this service is $0.97 per page, with a minimum charge of $4.00. Payment must be received prior to records being sent.

Patient Name: ________________________________Date of Birth: _______________

Telephone# ___________________________________

Patient Signature: ___________________________Date: _______________________