

CATHY T. LARRIMORE, MD AND ASSOCIATES

OBSTETRICS AND GYNECOLOGY
4181 HOSPITAL DRIVE, SUITE 104
COVINGTON, GEORGIA 30014
770.385.8954 PHONE
770.385.8590 FAX

CATHY T. LARRIMORE, MD, F.A.C.O.G.
ERINNE GRAHAM, M.D., F.A.C.O.G.

PATRICIA A. DETZEL, CNM, MSN
KERRY DEWBERRY, RNC, WHNP

REQUEST TO RELEASE MEDICAL RECORDS

Date _____

Patient Name: _____ Date of Birth _____

I hereby request and authorize *Cathy T. Larrimore, MD & Associates* to release my medical Records including office notes, laboratory results and radiology reports for the purpose of

- Completing requested consultation
- Transfer of Care
- Other

I understand this authorization includes release of all medical records including HIV results, records of psychiatric evaluation, drug or alcohol abuse treatment records and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously been taken in reliance thereof.

- Records to released to patient.
- Sent via mail and/or fax to:

Patient or Person Authorized to
Consent for Patient

Date

Relationship to Patient

Witness