

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 for Medical Information
Consent to and Authorization for Release of Medical Information**

Date: _____

Patient Name: _____ Date of Birth: _____

I hereby request and authorize Cathy T. Larrimore, MD and Associates to obtain records from:

Name of doctor or hospital

Fax: _____ Phone: _____

For the following types of information from my records (and any specific portion thereof):

All 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 disease. 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.

Please FAX my information to 770-385-8590

Patient or person authorized to consent
for patient

Date

Relationship to patient

witness