MEDICAL RECORDS RELEASE AUTHORIZATION

Center for Endometriosis Care

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

KENNY R. SINERVO, MD, FRCSC, LLC

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** ( )	
Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care have my permission to release information contained in the Medical Record of the above named patient. _____ (please initial)		
Information Requested (please be specific and enter date of service if known):		
Restrictions and/or Exclusions (if any):		
Purpose of Release:		
We 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 Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care 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:_____