KENNY R. SINERVO, MD FRCSC LLC
Center for Endometriosis Care

A COEMIG-Designated Center of Excellence in Minimally Invasive Gynecologic Surgery
A Center of Expertise in Endometriosis
6105 Peachtree Dunwoody Road | Building B, Suite 230 | Atlanta, GA 30328
Toll Free Telephone (866) 733-5540 | Direct (770) 913-0001 | Fax (770) 913-0005
Web: CenterForEndo.com | CenterForEndometriosisCare.com
Ken R. Sinervo, MD, MSc, FRCSC, ACGE, Medical Director
Nicholas Kongoasa, MD, FACOG
Robert B. Albee, Jr., MD, FACOG, ACGE

To the Patient: *to request release of your medical records and information* ***TO our Center FROM your current or past physicians****, please complete and* ***return it TO those providers*** *from whom you wish to obtain your records.* ***Please note; you may also be required to complete each provider's own individual release forms and are responsible for any fees associated with your request.***

To the Provider: *your kind assistance with the facilitation of this records release is greatly appreciated.*

Patient Information		
Patient Last Name	**First Name**	
Street Address		**Apt#**
City	**State**	**Zip**
Social Security #	**Home Telephone** ( )	
Date of Birth	**Alternate Telephone** ( )	
Dear Healthcare Provider: On behalf of Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care, we respectfully request the release of Medical Record(s) on behalf of the above-named patient.		
Information Requested: All office records for the past one (1) year AND if/where applicable, ANY/ALL pelvic surgery findings, pathology, operative notes, photos, imaging and diagnostic results.		
Restrictions and/or Exclusions (if any): Discs & films not needed. ***Written findings only***.		
Purpose of Release: Surgical consult.		
Please kindly release to us records on this patient's behalf to the following address:		

Kenny R. Sinervo, MD, FRCSC, LLC | Center for Endometriosis Care
KEN SINERVO MD, MSC, FRCSC, ACGE, MEDICAL DIRECTOR
6105 Peachtree Dunwoody Road | Building B, Suite 230 | Atlanta, GA 30328
TOLL FREE PHONE (866) 733-5540 | FAX (770) 913-0005

Name of person completing this form and relationship, if other than patient:

Signature _____ Date _____

THANK YOU FOR YOUR KIND ASSISTANCE.

Dear Provider(s): We **greatly appreciate** your kind courtesy and support on behalf of your above-named patient. ***Please make a copy of this release for your records. Thank you.***