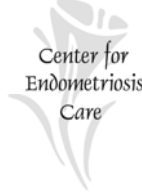


KENNY R. SINERVO, MD FRCSC LLC

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
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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.**