REQUESTED RECORDS

TO: Women for Women, PC
Dr. Felecia L. Dawson
P.O Box 570794
Atlanta, GA 30357-0608
(770)648-4956
Womenforwomen2@gmail.com

I _____ hereby authorize and request you to release my Medical Records to:

Doctor OR Hospital OR Self: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Telephone # _____ Fax# _____

Due to The Health Insurance Portability and Accountability Act (HIPAA) and Georgia State laws, Dr. Dawson must maintain and make available to you, her medical records for 10 years. These laws allow a fee to be charged to cover the expenses and labor costs needed to comply with these requirements.

Medical Records Retrieval and Coping Rates for State of Georgia according to Department of Community Health as of July 1, 2016 is $0.97 per page. You can call GA DCH if you have any question regarding current rates at 404-656-4496.

Credit Card # _____ Exp Date: _____

CVV # _____ Billing Zip Code: _____

Check Amount $_____ (please mail this request with your check)

I understand that the charge for this service is $0.97 per page, with a minimum charge of $4.00. Payment must be received prior to records being sent.

Patient Name: _____Date of Birth: _____

Telephone# _____

Patient Signature: _____Date: _____