West Augusta Obstetrics & Gynecology, P.C.
1126 Medical Center Drive
Augusta, GA 30909
706-863-5082/ 706-863-4082 Fax

REQUEST FOR PATIENT INFORMATION

To: ____
Name of Physician/Office/Facility

____
Fax/Email

____
Address

____
City, State & Zip Code

PLEASE PROVIDE RECORDS FOR FOLLOWING PATIENT:

____
Printed Name/ SSN/ Date of Birth

The requested information is used for treatment, payment and/or health care operations. Please EMAIL, FAX OR MAIL the records to:

Dr. ____
West Augusta Obstetrics & Gynecology, P.C.
1126 Medical Center Drive
Augusta, GA 30909
706-863-4082 Fax
westaugustaobgyn@yahoo.com

Description of information requested (check all that apply)

__ Entire medical record, including demographics

__ Medical Date/Information as related to:

__Lab data, Date_________________
__ Progress Notes, Date____________
__ Obstetrical Notes, Date__________
__ History & Physical, Date_____________
__ Mammogram Report, Date___________
__ Mammogram Film, Date_____________
__ Other, Date____

Signature: ____Date: _______________________