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

REQUEST FOR PATIENT INFORMATION

To: _____
Name of Physician/Office/Facility

_____
Address

_____
City, State and Zip Code

Please provide a copy of records described below pertaining to the following patient:

_____
Printed Name/SSN/ Date of Birth of Patient

The information is to be used for treatment, payment, and or health care operations. Send the copied information to: Dr. _____
West Augusta Obstetrics & Gynecology, P.C.
1126 Medical Center Drive
Augusta, Georgia 30909
Or fax to 706-863-4082

Description of the information requested (check all that apply)

( ) The entire medical record, including demographic information

( ) Medical Data/Information as related to:
() Lab data, Date_____ () History and Physical, Date_____
() Progress Notes, Date_____ () Mammogram report, Date_____
() Obstetrical Notes, Date____ () Mammogram film, Date_____
() Specific condition_____
() other:_____

_____
Signature of Patient Date