Michael D. Randell, MD, FACOG

Fellow, American College of Obstetricians and Gynecologists
Diplomate, American Board of Obstetrics & Gynecology

Specializing in minimally invasive gynecologic surgery and robotics

5667 Peachtree Dunwoody Road, Suite 280 Atlanta, Georgia 30342
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REQUEST & AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(ALL INFORMATION MUST BE COMPLETED)

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize the practice identified to the right to release healthcare information of the patient named above to:

MICHAEL D. RANDELL, MD, FACOG
5667 Peachtree Dunwoody Road, Suite 280
Atlanta, Georgia 30342
Fax: 404.250.4423 Email: office@obgynatlanta.com

Practice
Name:_____
Address:_____
City, State, Zip:_____

Phone_____ Fax_____

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

[List here]

○ All healthcare information ○ Other

[Additional information]

Definition: Sexually Transmitted Disease (STD) includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to Dr. Randell.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to Dr. Randell.

Patient Signature: _____ Date Signed:_____

THIS AUTHORIZATION HAS NO EXPIRATION UNLESS WITHDRAWN IN WRITING.