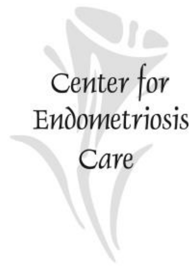

6105 Peachtree Dunwoody Road | Building B | Suite 230 | Atlanta, GA 30328
Direct (770) 913-0001 | Fax (770) 913-0005
CenterForEndo.com

Medical Records Retrieval:

After your surgery, you will be provided with **two sets of operative records and reports at no cost; one for you and one for your local provider**. We are happy to accommodate your future requests for any additional copies that you may wish to obtain at a later date. We adhere to Georgia state law regarding costs for additional retrieval and copying costs, as follows:

GEORGIA CODE O.C.G.A. § 31-33-3 Current as of July 1, 2017
Costs of copying and mailing; patient's rights as to records:

Administrative Fee:	$25.88
Pages 1 - 20:	$0.97 per page
Pages 21 - 100:	$0.83 per page
Pages 101+:	$0.66 per page
Certification Fee:	$9.70 (only if required)
Secure mail Fee:	$20.00

Note: Rates do not apply to records requests necessary to make or complete an application for a disability benefits program or vocation rehabilitation program.

Requests must be sent with at least 30 days notice. Applicable charges will be obtained upfront and you will be emailed or otherwise sent any release forms that might be required prior to release of your records. Thank you for your understanding.

Continued –

MEDICAL RECORDS RELEASE AUTHORIZATION

If you need help completing this form, please contact us at 770-913-0001.

Patient Information		
Patient Last Name	**First Name**	
Street Address	**Apt#**	
City	**State**	**Zip**
Social Security #	**Home Telephone ( )**	
Date of Birth	**Alternate Telephone ( )**	
Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care have my permission to release information contained in the Medical Record of the above named patient. __________ (please initial)		
Information Requested (please be specific and enter date of service if known):		
Restrictions and/or Exclusions (if any):		
Purpose of Release:		
We will provide the information as requested above to the following party (if patient is the intended recipient, please indicate "self"):		
Name		
Attention of	**Telephone**	**Fax**
Street Address	**Suite/Room**	
City State Zip		

Name of person completing this form and relationship, if other than patient:

Printed Name: ____

Signature: ____

Date: ____

Continued –

I hereby authorize Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes.

I am aware that the CEC cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at the CEC may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date.

I understand that I cancel this authorization in writing at any time, except to the extent that the CEC has relied upon it for the purposes stated above.

I further understand that if I cancel this request after the CEC has already sent the requested records, the CEC will not retrieve those records.

___________________________________ ___________________________________

Printed Name (parent or guardian if minor) Signature

____

Date

Please make a copy of this release for your records.