



CASTILLO * WALTERS OB/GYN
A Division of Atlanta Women's Health Group, P.C.

4488 North Shallowford Road NW.
Suite 210
Atlanta, GA 30338
Telephone (770) 730-0451

3630 Savannah Place Drive
Building 100, Suite B
Duluth, GA 30096
Telephone (678)474-0203

Authorization to Release Records from Castillo-Walters OB/GYN

I hereby authorize and request that you release a copy of my medical records covering the period from ____/____/____ to ____/____/____ to _____.

Address _____

Name: _____ Maiden Name _____

Address: _____

Social Security # _____ DOB: _____

Phone: _____ Work Phone: _____

Reason for Request (Must be filled in) : _____

I understand this authorization includes release of ALL medical records including HIV records, psychiatric mental illness, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. This authorization and consent will expire 60 days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

Signature _____ Date _____

Office use only

*Request received by _____ on ____/____/____
Release from Billing Department on ____/____/____ by _____*

Please allow 7-10 business days for the release of your records. You will be notified if this process will take longer
The first release of records is free of charge . Any request after that will be \$35 dollars.