



## CASTILLO \* WALTERS OB/GYN

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 to Castillo-Walters OB/GYN

I hereby authorize and request that you release a copy of my medical records covering the period from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ to Dr. \_\_\_\_\_ at

**4488 N. Shallowford Rd.  
Suite 210  
Dunwoody, GA 30338  
Phone: (770) 730-0451  
Fax: (770) 730-0141**

**3630 Savannah Place Drive  
Building 100, Suite B  
Duluth, GA 30096  
Phone: (678)474-0203  
Fax: (678)474-0207**

Name: \_\_\_\_\_ Maiden Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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 \_\_\_\_\_

Requesting Records From: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Reason for Request(Must be filled out) : \_\_\_\_\_