

Scott Gynecology & Pelvic Surgery, PC

Medical Record Release Form

Sign and Fax to your former offices or
bring in with you for your appointment.

Our Fax: 678-264-0939

Date: _____/_____/_____

Practice Marietta OB-GYN Affiliates
625 Church Street, Marietta, GA 30060
Fax: 770-424-7449

I hereby authorize and request you to release my complete medical record in your possession to:

Dr. Vincent S. Scott
Scott Gynecology & Pelvic Surgery, PC
5041 Dallas Highway, Bldg 1, Suite G
Powder Springs, GA 30127
Fax #: 678-264-0939

My Name: _____

D.O.B.: _____

Address: _____

Signature: _____