

# Scott Gynecology & Pelvic Surgery, PC

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Board Certified: Female Pelvic Medicine and Reconstructive Surgery (Urogynecology)

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## MEDICAL RECORDS RELEASE FORM

By signing below, I authorize Scott Gynecology & Pelvic Surgery, PC to release my complete health record to myself or the medical provider listed below. I attest that the records I am requesting belong to me personally or I am the legal guardian of the person whose records I am requesting.

*Fax to 678-264-0939 OR email to [medicalrecords@scottgynecology.com](mailto:medicalrecords@scottgynecology.com) OR mail to address above*

**My Name (print):** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Release my records TO:

Provider: \_\_\_\_\_

Provider phone number: \_\_\_\_\_

Release my records to my new provider the following way:

By Fax Fax number: \_\_\_\_\_

By Regular Mail (I understand that a fee of \$30.00 must be paid before records are released.)

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

\_\_\_\_\_

\_\_\_\_\_

By Email (Email may NOT be secure. Scott Gynecology is not responsible if records are lost.)

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_