All WOMEN'S HEALTH

Tania N. Morgan-Bowen, MD, MPH
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MEDICAL RECORDS RELEASE

Physician's Name ____

Physician's Address_____________________________________

City, State, Zip ___________________________

Phone __________________

Fax __________________

Patient's Name ____________________________________

Patient's Date of Birth ______________________________

Patient's SS Number ________________________________

I request that my records be released to the following Physician:

Tania N. Morgan-Bowen, MD, MPH
5354 Reynolds Street, Suite 303
Savannah, GA 31405

I place no limitation on history, illness or diagnosis including any treatment for alcohol, drug abuse, HIV test, or psychiatric disorders.

This consent can be revoked at any time, except to the extent that the organization which is to make the disclosure has already taken action in reliance to it.

Signature ________________________________ Relationship ____________________

Date ________________