Darien Women's Health CLINIC
Darien Primary Care, INC.

1135 North Way Ste E Darien, GA 31305 Office: 912-437-3025 Fax 912-480-0669
Any Mailed records please mail to: P.O. Box 2690 Darien GA 31305

Consent to Release Records

I _____, request my medical records to be released from

_____

TO: Darien Women's Health / Darien Primary Care Inc. for the purpose of receiving treatment.

Any records that I **DO NOT** wish to be released include _____.

This request remains in effect until _____,or indefinitely, if left blank.

Signature_____ Date_____

Date of Birth_____

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Records being released to the patient are printed at a cost of $.50 per page. This is our actual cost for materials. **Faxing records is free.**

I _____ request and authorize the release of my health records from Darien Women's Health / Darien Primary Care Inc. to the following provider or person:

Name of Business or Person wanting records:_____

Physical Address/Phone_____

Fax Number_____

Signature_____ Date _____