

Piedmont Reproductive Endocrinology Group, P.A.

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REQUEST FOR MEDICAL INFORMATION

TO: _____
Name of Facility/Practice that Medical Information is being requested from

Address

City State Zip



Patient Name: _____

Date of Birth: _____

Social Security Number: _____



I hereby authorize Piedmont Reproductive Endocrinology Group, P.A.
To release any information contained in my medical record in connection with treatment
and/or hospitalization to _____.

A. Complete or all

B. _____

C. _____

Date

Patient/Guardian/Legal Representative

Please forward information to: