**Women's Health Associates, P.C.**
**980 Johnson Ferry Road, N.E., Suite 720**
**Atlanta, Georgia 30342**
**Phone: 404-252-3898**
**Fax: 404-843-0719**

**Winifred Lin Soufi, M.D.,Ph.D.**
**Jonathan S. Ehrlich, MD**
**Michele C. Houston, MD**
**Phoebe M. Sun, MD**
**Kelley B. Dopson, MD**
**Steven Rabin, MD**
**Sally J Brumbill, PA-C**
**Christine Hoey, MSN, APRN**

## MEDICAL RECORDS RELEASE AUTHORIZATION

To: _____
(Physician Name)
_____
(mailing address)
_____
(city, state & zip code)

I, _____, authorize and request release of my medical
(Patient Name)
records to: **Women's Health Associates, P.C.**
**980 Johnson Ferry Road, N.E.**
**Suite 720**
**Atlanta, Georgia 30342**

☐ **Winifred L Soufi, MD, Ph.D**
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☐ **Sally J. Brumbill, PA-C**
☐ **Christine Hoey, MSN, APRN**

the complete history/records in your possession, concerning my illness and or treatment: _____

Patient Name: _____ SS# _____
Address: _____ Birth-date: _____
_____

Former name and address (if applicable) _____

_____

Patient Signature: _____
(if relative state relationship)

Witness: _____

☐ By checking this box you certify that the information you have entered is true