



Ruthann F. Rees, M.D., Ph.D., FACOG

AUTHORIZATION TO REQUEST HEALTH CARE INFORMATION

Patient Name: _____

Maiden Name: _____

DOB: _____ SSN: _____

I request and authorize _____
to release health care information of the patient named above to:

Physician/Practice: OB/GYN Specialists of Columbus

Address: 2000 10th Avenue, Suite 380, Columbus, Georgia 31901

Telephone: 706-324-0471 FAX: 706-324-0473

This request and authorization applies to:

Health care information relating to the following treatment, condition or dates:

All health care information

Other _____

Patients Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Please fax to our secure fax number (706) 324-0473



2000 10th Avenue, Suite 380, Columbus, GA 31901

Phone: 706-324-0471 Fax: 706-324-0473

www.obgynsoc.com