

Women's Care Specialist
Obstetrics and Gynecology
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize Dr. _____
to release my medical records to _____ and I release
Dr. _____ from any and all liability that may arise from the
release of the information requested.

Signed _____

Witness _____

Date _____

Name (if different) _____

Date of Birth _____

Social Security Number _____

Address to have records mailed to

Phone _____

This authorization will expire on _____.

****Medical requests generally take 10-14 days to process and we can not fax records****

Robin Higgins Practice Manager