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: 1604 12th Street, Columbus, Georgia 31906

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

1604 12th Street Columbus, GA 31901
Phone: 706-324-0471 Fax: 706-324-0473
www.obgynsoc.com