KENNY R. SINERVO, MD, MSC, FRCSC, ACGE, LLC & ASSOCIATES

Center for Endometriosis Care

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MEDICAL RECORDS RELEASE REQUEST & AUTHORIZATION

Patient Information	
Patient Full Name	
Address	
Date of Birth	**Telephone**
Dear Healthcare Provider: On behalf of Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care, we respectfully request the release of Medical Record(s) on behalf of the above-named patient.	
Information Requested: Surgical pathology reports (if any), operative notes (if any), surgical photos (if any), imaging and/or diagnostic report(s).	
Restrictions and/or Exclusions (if any): No other records are necessary.	
Purpose of Release: ***SURGICAL CONSULT. PLEASE RELEASE DIRECTLY TO THE PATIENT IN ADVANCE OF THEIR CONSULT.***	
Name of person completing this form and relationship to patient: Name:_____ Relationship:_____ Signature: _____ Date: _____	
THANK YOU FOR YOUR KIND ASSISTANCE.	

Dear Provider(s): We greatly appreciate your kind courtesy and support on behalf of your above-named patient. *Please make a copy of this release for your records. Thank you.* Please call us at 770-913-0001 with any questions.