REQUEST FOR RELEASE OF MEDICAL RECORDS TO BE SENT TO ATLANTA GYN ASSOCIATES, PC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize

____
____
____
____
(Phone number)
____
(Fax number)

to use and/or disclose certain protected health information (PHI) to

ATLANTA GYN ASSOCIATES
2550 Windy Hill Road, Suite 115
Marietta, GA 30067
770/980-1818
770/980-1873 fax

This authorization permits to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): ____
____.

The information will be used or disclosed for the following purpose:

____.

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on ____.
{Expiration Date or Defined Event}.

I do not have to sign this authorization in order to receive treatment from ATLANTA GYN ASSOCIATES, PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Signed by:________________________________ ___________________________________
Signature of Patient or Legal Guardian | Date

___________________________________ ___________________________________
Print Name of Patient or Legal Guardian | Relationship to Patient

____
Patient's Date of Birth

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION