ATLANTA GYN ASSOCIATES, PC

REQUEST FOR RELEASE OF MEDICAL RECORDS
PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize ATLANTA GYN ASSOCIATES to use and/or disclose certain protected health information (PHI) about me to

____
Name of Entity to receive this information

____
Address of Entity

____
Phone number   Fax number

This authorization permits ATLANTA GYN ASSOCIATES 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}.

The charge for copying is $20.00. Please make check payable to ATLANTA GYN ASSOCIATES.
Please allow up to 3 weeks (15 working days) for processing records.

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

AGA095:R07/04