



ATLANTA GYN ASSOCIATES, PC

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ATLANTA GYN ASSOCIATES, PC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

By signing this authorization, I authorize ATLANTA GYN ASSOCIATES to use and/or disclose certain protected health information (PHI) to myself or physician specified. I will then give my records to my health care provider or insurance company.

Fax or Mail to:

Name

Address

Fax number (preferred method of release)

Contact number

This authorization permits ATLANTA GYN ASSOCIATES to use and/or disclose the following individually identifiable health information about me:

- Lab Results Mammogram Reports Dexa Report Others: _____
- Pap Smear Pathology Reports Office Procedures _____

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

_____.

I understand that Atlanta GYN Associates, PC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Atlanta GYN Associates, PC from all legal liabilities that my arise from this authorization. This authorization does not expire unless you notify us.

The charge for processing the first 20 pages is \$20.00; 21-100 pages is .80¢ per page. Please allow up to 2 weeks (10 working days) for processing records. Credit cards may be called in to 770.980.1818 ext. 301 Tiffany Crisp. **Fee must be paid prior to processing.**

Signed by: _____
Signature of Patient or Legal Guardian Date

Print Name of Patient Relationship to Patient

Patient's Date of Birth

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

All records are reviewed by physician before release. Fee for records includes pulling chart, review by record keeper, complete physician review, taking chart apart, photocopying, reorganizing & putting sections of charts back together, filing request forms, documenting activity, checking follow-up, refilling chart, and getting papers to requestor.

ADULT
ADOLESCENT
PEDIATRIC
GYNECOLOGY

AGA095:R02/09

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