



**ATLANTA GYN
ASSOCIATES, PC**

**CHERYL L. HECHT, M.D.
KRISTI M. MULCHAHEY, M.D.
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**REQUEST FOR 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
Doctor/Facility

(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:

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

Purpose of disclosure (Patient's Request, Insurance, Follow-up Care, and etc.):

_____.

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 not expire unless specified. _____.

(Expiration Date)

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 (ex: we may have to send a copy to your insurance company) 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 is required to send the info to your insurance company or a law office.

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

ADULT
ADOLESCENT
PEDIATRIC
GYNECOLOGY

AGA090:R02/09

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