



# The Women's Center, PC

Providing Individualized Care for Women

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**Standard authorization of use and disclosure of protected health information:**

I hereby give authorization to release the following information:

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I hereby authorization this information to be released to/from:

**The Women's Center PC**  
**140 Eagles Spring Ct.**  
**Stockbridge, Ga. 30281**  
**Ph# 770-302-0878 Fax# 770-302-0883**

I hereby authorization this information to be released to/from:

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**Right to terminate or revoke authorization:**

You may revoke or terminate this authorization by submitting a written revocation to The Women's Center PC. You should contact the practice administrator to terminate authorization.

**Potential for re-disclosure:**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

**Name of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

**Social Security:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

