Signature Women's Healthcare

Hillandale Office
5900 Hillandale Drive, Suite 245
Lithonia, Georgia 30058
Phone: (678) 380-1200
FAX: (770) 323-6859

Cruse Road Office
2775 Cruse Road NW, Suite 2101
Lawrenceville, Georgia 30044
Phone: (678) 380-1200
FAX: (770) 609-1984

Dr. Tyndal Jones □
Dr. Jacqueline Hayles-Patterson □

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Patient Name: _____
Date of Birth: _____
Patient last 4 digits of SS#: XXX – XX- _____
Address: _____
City: _____ State: _____ Zip code: _____

Physician Office Authorized to RELEASE Information

Practice/Facility Name: _____
Telephone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip code: _____

□ **All Medical Records** □**Specific date range** _____ □ **Last Pap smear** □ **OB Record** □**Other** _____

Physician Office Authorized to RECEIVE Information

Practice/Facility Name: _____
Telephone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip code: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in **six months** or on this date listed _____. I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization. I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE; ____ DO NOT RELEASE (Indicate with a check mark).

_____ _____
Signature of Patient or Authorized Representative Date