

Atlanta Obstetrics & Gynecology Associates

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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize Atlanta Obstetrics & Gynecology Associates to use or disclose medical records as described below: Purpose of Use or Disclosure: □ At the request of the individual Other _____ Patient's Full Name: ______ SSN: Date of Birth: Home Number: Work Number: Current Address: I further request and authorize use or disclosure of the medical records checked below to (please provide name and address): This authorization applies to the information checked below for the following date(s) of service: The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance. ☐ Entire Record ☐ Mammography Reports ☐ Mammography Films ☐ Bone DEXA Reports ☐ Laboratory Test Results □ Other I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and my then no longer be protected by the Federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing to the extent that the entity identified above has taken action in reliance on this Authorization. Written revocations must be submitted to the Privacy Officer at our office. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. Atlanta Obstetrics & Gynecology Associates shall not condition treatment on the receipt of this Authorization. I further understand that this Authorization is valid for a period of 90 days from today's date. Patient's or Legal Guardian's Signature Today's Date Patient Name (please print) As Legal Guardian, my relationship to the patient is ______. Any document outlining such authority should be attached. The patient is unable to sign because _____.

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There may be fees for provision of any or all requested information.