DUNWOODY OBSTETRICS & GYNECOLOGY, of GA

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1829 INDEPENDENCE SQUARE
DUNWOODY, GA 30338
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Patient Name: _____ Date of Birth: _____

Maiden/Other Name: _____ MRN (if known): _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

1. RECEIVING PARTY & DELIVERY METHOD - CHOOSE ONE:

☐ Mail the records/information to me (see fee below).

☐ I will pickup the records from DOBG's office (see fee below).

2. PURPOSE OF RELEASE/DISCLOSURE- CHOOSE ONE:

☐ My personal records ☐ Attorney

☐ Medical Care/Second Opinion ☐ Disability

☐ Other: _____

☐ Release the records to (physician name if for medical care): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax Number: _____

3. DESCRIPTION OF HEALTH INFORMATION/RECORDS TO BE DISCLOSED- CHOOSE ONE:

☐ Send complete medical record ☐

☐ Send partial medical records: Specify dates of service: From: _____ To: _____

☐ Send specific section circled below: Specify dates of service: From: _____ To: _____

History and Physical	Consultations	MRI Report
Discharge Summary	Office Notes	Lab Results
Operative Reports	Other: _____	

☐ ***You must check this box if you are also requesting billing records***

4. EXPIRATION, REVOCATION OF AUTHORIZATION, & RE-DISCLOSURE

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization has no expiration date. When my health information is released pursuant to a valid authorization, the information released may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

5. FEE FOR RECORDS

Federal and state laws allow a fee to be charged for copying patient records and I will be responsible for the payment of such fees, unless the records are sent directly to a physician or healthcare facility. Patient copy fees vary based upon federal and state law, which take into account the expenditure to produce the requested documents. The minimum fee amount is $25 and is payable prior to the preparation of the medical record.

6. RELEASE AND WAIVER

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, chemical dependency/alcohol abuse, communicable or infectious diseases (ie. AIDS, HIV, ARC, TB, and hepatitis). I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Dunwoody OBGYN, each of their Physicians and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above. In cases where someone other than the patient executes the authorization, I understand documentation may be required to support the disclosure of personal health information as required by state and federal law. In most cases, records are processed within seven days. Please be aware that federal and state law allows healthcare providers 30 days to respond to written requests for records.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Printed Name Relationship to Patient

Fax requests to: 770-828-0637. Mail request to: Dunwoody OBGYN of GA, ATTN: Medical Records 1829 Independence Square, Dunwoody, GA 30338