Arbor Obstetrics and Gynecology, P.C.
4360 Chamblee-Dunwoody Rd
Atlanta, Georgia 30341
Tel: 770-399-5055 Fax: 770-399-9638

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____to Use and disclose certain health information (PHI) about me to Arbor OB/GYN. This authorization permits _____ to use and/or disclose the following individually identifiable health information about me. (please choose records requested)

[] **All records** [] **All prenatal records** [] **Last notes and Labs**

[] **Other** (please describe records requested) _____
_____
_____

This authorization will expire in 30 days.

When my information is used or disclosed pursuant to this information, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy rule.

_____ _____
Name of patient Signature of witness

_____ _____
Signature of Patient Date

_____ _____
Date of birth SSN

_____
Name and number of office with requested records.