Arbor Obstetrics and Gynecology, P.C.
4360 Chamblee-Dunwoody Rd - Suite 370
Atlanta, GA 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 Arbor OB/GYN to use and/or disclose certain protected health information (PHI) about me to_____.
This authorization permits Arbor OB/GYN to use and/and or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates of service, level of detail to be released, origin of information, etc.)
_____
_____
_____.

The information will be used or disclosed for the following purpose:

_____.
If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

Arbor Ob/Gyn(circle one): **will** **will not** receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Arbor OB/GYN. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization. My written revocation must be submitted to the Privacy Officer at: 4360 Chamblee-Dunwoody Road, Suite 370 Atlanta, GA 30341.

_____ _____
Signature of Patient Signature of Witness

_____ _____
Name (please print) Date of Birth

_____ _____
Date S.S.N.