AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

Patient Name: _____**Street Address**: _____

City: _____**State**:_____ **Zip Code**: _____ **Date of Birth**: _____

Patient's Phone:_____ **Social Security Number:**_____

I hereby authorize North Pointe OB/GYN of Cumming LLC
Phone: 770-886-3555; Fax: 678-807-6050; www.npobgyn.com

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to: _____

Street Address: _____**P.O. Box**: _____

City: _____**State**: _____ **Zip Code**: _____

Please indicate the information or types of information to be disclosed, including dates if necessary:

_____

Specify Dates (or date ranges) if necessary: _____

This request is for the purpose of: _____

Records to be: ____ Faxed to (_____) _____(no fees for faxing records)

____Mailed (fees collected in advance of processing)

____Picked up (fees collected in advance of processing)

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).

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. I understand that I may be billed for the charges incurred in processing my request and agree to pay any and all charges in full. Please direct any inquiries to North Pointe OB/GYN Medical Records 770-886-3555 Option 4. Thank you.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Representative's Authority to Act on Behalf of Patient Signature of Witness