Atlanta Obstetrics & Gynecology Associates

a Division of Atlanta Women's Healthcare Specialists, LLC
275 Collier Road, NW, Suite 100-C
Atlanta, Georgia 30309
Telephone: 404.355.0320 Fax: 404.351.0909

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 or dates 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 abuse.

☐ Entire Record ☐ Mammography Reports ☐ Mammography Films
☐ Laboratory Test Results ☐ Bone DEXA Reports ☐ Other _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of the information and may 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 Name (please print)	Patient's or Legal Guardian's Signature	Today's Date

As Legal Guardian, my relationship to the patient is _____. Any document outlining such authority should be attached. The patient is unable to sign because _____.

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