

ATHENS OBSTETRICS & GYNECOLOGY, LLC

740 Prince Avenue Bldg. 3

Phone: (706) 548-4272

Fax: (706) 548-9181

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____
(please print) Phone: _____

By signing this authorization, I authorize Athens OB/Gyn to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below:

This authorization permits Athens OB/Gyn to use or disclose to:

(name and address of Person or Entity to receive the information):

Name: _____

VIA: Mail

Address: _____

Fax # _____

City, State, Zip _____

To be picked up

REASON FOR REQUEST:

Selected new physician in the area Second opinion/Consult Change of Insurance

Moving out of town Other _____

Specific records to be disclosed:

Copy entire chart

Copy Dates from: _____ to _____

Copy Specific information (please specify) _____

This authorization will expire on _____ Revoked: _____
(Expiration Date or Defined Event)

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 HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Athens OB/Gyn has acted in reliance upon this authorization. My written revocation must be submitted to Athens Ob/Gyn's Privacy Officer at 740 Prince Avenue, Bldg. 3, Athens, GA 30606.

Signed by: _____ Date _____

Print Name: _____ Relationship: _____