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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

Name of Patient____Medical Record # ____________
Date of Birth ____
Evening Phone# ____ Daytime Phone# ______________________________
Address ____City ______________________ State___________ Zip ________

I hereby authorize: ____
(Practice Name, Address, Phone, Fax)
____

To release information from my medical record to:

____
(Practice Name, Address, Phone, Fax)
____

At this time, I am requesting that the following information be released (check all that apply):

________ My complete Medical Records including but not limited to office notes, consultation and operative reports, medication history, phone call documentation, laboratory and imaging reports.

________ Complete records of my medical care for the following specified dates of treatment:

From: ___________________________ To: _________________________

________ Records of my medical care for the following medical condition(s) only:

____
____

_______ Other: (please specify): ____

-This includes all records of the patient's treatment and shall include any records whether oral, written or electronic that may contain information regarding psychiatric treatment and/or drug, alcohol usage or treatment for such usage or abuse, and/or AIDS confidential information.
-Peachtree City Obstetrics and Gynecology, P.C, its officers, directors, associates and agents are hereby released from any legal liability that may arise from the release of information requested.
- I understand by signing this request that Peachtree City Obstetrics and Gynecology,PC, is not responsible for lost, misplaced or stolen medical information/records once they are released. I also understand by signing this request that Peachtree City Obstetrics and Gynecology,PC, in accordance to federal and state regulations, may charge a reasonable fee for copying your records and may also additionally charge for postage if you request that your records be mailed to you.
- When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Peachtree City Obstetrics and Gynecology, PC, has acted in reliance upon this authorization. My written revocation must be submitted to Peachtree City Obstetrics and Gynecology, PC's Privacy Officer at 210 Clover Reach, Peachtree City, GA 30269.
In any event, this consent will expire without revocation 90 days from the date signed.

This consent is executed on the _____________ day of ______________________, 20_________

Signature of Patient:____

If consent is necessary from a person authorized to give consent other than the patient:

Signature of Patient Representative: ___________________________________**Relationship to Patient:** ____________