Peachtree City Obstetrics and Gynecology, P.C.

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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATIONTO THIRD PARTIES

Patient Name: _____ Last 4 Digits of SSN: _____

Previous Name, if applicable: _____

Address: _____City:_____State: _____ Zip: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

1. I authorize representatives **from** the following facility to disclose the health information as directed below:

_____

(Practice Name, Address, Phone, Fax)

_____

2. Please send my health information **to**:

_____

(Practice Name, Address, Phone, Fax)

_____

3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

- ☐ Complete medical record (Please specify dates of service) _____
  OR
- ☐ Partial Medical Record (Please specify below)
- ☐ Electronic Continuity of Care/Electronic Abstract (Please specify dates of service) _____
- ☐ *You must check this box if you are also requesting Billing Records*

Information	Date	Information	Date
☐ History & Physical	_____	☐ Office Notes	_____
☐ Discharge Summary	_____	☐ Lab Results	_____
☐ Operative Notes	_____	☐ Pathology Reports	_____
☐ Mammogram Reports	_____	☐ Itemized Bill	_____
☐ Mammogram CD's	_____	☐ Other: _____	

4. PURPOSE OF DISCLOSURE

- ☐ At my request
- ☐ Other: _____

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.**

_____ _____ _____

Signature of Patient (or Patient's Representative) Date Time

FOR OFFICE USE ONLY: DATE RECEIVED: _____ MRN#: _____ DATE PROCESSED: _____
FORMAT SENT: _____ MEDICAL STAFF INITIALS: _____