ATHENS OBSTETRICS & GYNECOLOGY, LLC
658 N. CHASE STREET, SUITE 301
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 658 N. Chase Street, suite 301, Athens, GA 30601.

Signed by:_____ Date_____

Print name:_____ Relationship:_____

**** There is a $25 fee for medical records and additional charges may apply****