ATHENS OBGYN
OBSTETRICS • GYNECOLOGY FOR ALL WOMEN
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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(MEDICAL RECORDS RELEASE)

Patient Name:	Date of Birth:
Patient Street Address:	
City/State/Zip:	Phone:

I authorize the use or disclosure of the above-named individual's health information as described below.
The following individual or organization is authorized to make the disclosure.

Name of Facility/Dr.
Releasing Records: _____

Fax #: _____Phone #: _____

The type and amount of information to be used or disclosed is as follows:

DESCRIPTION OF RECORDS BEING REQUESTED: The applicable dates of service or treatment period→_____

☐ Entire Medical Record	☐ Radiology/Imaging	☐ Labs	☐ Clinic Notes
☐ Abstract Medical Record	☐ Pathology Report	☐ Operative Notes	☐ Other _____

I, the patient (or person authorized to consent for the patient), hereby request that you release to:

ATHENS OBSTETERICS & GYNECOLOLOGY
658 N. Chase Street, Suite 301
Athens, GA 30601
FAX: 706-548-9181

I understand this authorization includes the release of all medical records including Human Immunodeficiency virus records, Psychiatric, Drug/Alcohol abuse records, Venereal Disease, and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has been previously taken in reliance hereof.

Signature:_____ Date:_____