



OBSTETRICS • GYNECOLOGY FOR ALL WOMEN
658 North Chase Street, Suite 301, Athens GA 30601

Ruth M. Cline, M.D., FACOG
Rachel F. Murthy, M.D., FACOG
Meredith J. Bolton, M.D., FACOG
Katie Sells, WHNP

Andrew H. Herrin, M.D., FACOG
Rebecca L. Flectcher, M.D., FACOG
Cristina Elstad, M.D., FACOG

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**