ATLANTA OBSTETRICS & GYNECOLOGY SPECIALISTS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM ATLANTA OBSTETRICS & GYNECOLOGY SPECIALISTS, LLC

By signing this authorization, I authorize Atlanta Obstetrics & Gynecology Specialists, LLC to use and/or disclose certain protected health information (PHI) about me to

Name of entity to receive this information	Phone number	Fax Number

Address

This authorization permits Atlanta Obstetrics & Gynecology Specialists to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

The information will be used or disclosed for the following purpose:

_____.

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.
{Expiration Date or Defined Event}.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Atlanta Obstetrics & Gynecology Specialists, LLC. In fact, I have the right to refuse to sign this authorization. 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 HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at: 5445 Meridian Mark Rd., Suite 430

Address

Atlanta	GA	30342
City	State	Zip Code

Signed by:_____ _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient | Date

_____ _____
Print Patient's Name | Patient's Date Of Birth

FOR INTERNAL PURPOSES ONLY:

Date Request Received:_____

Confirmed: ❒Via Phone ❒In Person Initials:_____ Date:_____