ATLANTA OBSTETRICS & GYNECOLOGY SPECIALISTS, LLC

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

By signing this authorization, I authorize ______________________________
Name of entity to disclose this information

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to use and/or disclose certain protected health information (PHI) about me to:

ATLANTA OBSTETRICS & GYNECOLOGY SPECIALISTS

- ❑ **5445 Meridian Mark Rd., Suite 430**
  Atlanta, GA 30342
  (404) 252-5196
  Fax (404) 252-2414
- ❑ **3400-C Old Milton Parkway, Suite 200**
  Alpharetta, GA 30005
  (770) 667-7440
  Fax (770) 667-7425

This authorization permits 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.).

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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 not receive payment or other remuneration from **ATLANTA OBSTETRICS & GYNECOLOGY SPECIALISTS** 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. 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.

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

______________________________ ____________________ __________
Patient's Name | Social Security Number | DOB

______________________________ ____________________
Print Name of Patient or Legal Guardian | Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received:___________

Confirmed: ❑Via Phone ❑In Person Initials:__________ Date:___________