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:_____**