MATERNAL GYNERATIONS

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Call 770.513.4000 | ***Fax 770.237.2523***
MaternalGynerations.net

AUTHORIZATION FOR USE OR DISCLOSURE

OF PROTECTED HEALTH INFORMATION

(If requesting records from Maternal Gynerations, please allow 7-10 business days)

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip:_____

Social Security #: _____ Primary Phone#: _____

RELEASE RECORDS FROM:
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

RELEASE RECORDS TO:
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

INFORMATION TO BE RELEASED:
____ My complete office notes/lab results
____ History and Physical Exam
____ Lab Report
____ X-Ray Report
____ Other (specify) _____
From & To Dates: _____
Purpose of Disclosure_____

I understand that this health information may include HIV related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of this information. This material shall not be transmitted to anyone without signature consent provided below.

I understand that this authorization will expire two years from my last date of visit. A photocopy of this form will be considered as valid as the original.
I understand that I may revoke this authorization at any time by notifying the Privacy Officer where my records are retained.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.

_____ **OR** _____

Signature of Patient **Date** **Parent/Legal Guardian** **Date**

Relationship to Patient: _____