MyOBGYN, PC **Specialists in Obstetrics & Gynecology**

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Patient Authorization for Use and Disclosure of Protected Health Information

TODAY'S DATE _____

I, _____, Authorize and Request the following to release my records as indicated:

FROM: Doctor Name: _____ Phone: _____
Address: _____ Fax: _____
_____

Covering the period(s) of my health care from _____to_____ or: **ALL DATES** (circle)

TO RELEASE MY: ☐ Lab Results ☐ X-ray Results/Ultrasound Results
☐ Pap Results ☐ Complete Medical Records
☐ Other (please specify) _____

SEND TO: Name: _____ Phone: _____
Address: _____ Fax: _____
_____

Please release records via: ☐ Fax ☐ Mail ☐ Will Pick Up
(**Choose One Option)**
Reason for Release: _____

This authorization will expire on _____. If no date specified, authorization expires in 180 days.

I am aware that the information in the Requested Medical Records may be of a sensitive nature. By signing this release, I am granting permission for information pertaining to the below mentioned areas to be released. I waive any privilege or confidentiality existing under Federal or State Law regarding such information, including, but not limited to, Protection Afforded to:

(1) Communications made to a Psychiatrist (O.C.G.A. 824-9-21)
(2) Communications made to a Licensed Applied Psychologist (O.C.G.A. 843-36-16)
(3) Medical Information Concerning Drug Dependency (O.C.G.A. 828-5-17)
(4) Medical Information Concerning Alcohol and Drug Dependency (O.C.G.A. 837-1-166)
(5) Medical Information Regarding Mental Illness (O.C.G.A. 837-4-125)
(6) Medical Information Concerning Mental Retardation (O.C.G.A. 837-4-126)
(7) Medical Information Concerning Alcohol and Drug Abuse (42 C.F.R. Part 2)
(8) AIDS Confidential Information (O.C.G.A. 831-22-9.1 and 824-9-47)

I do not have to sign this authorization in order to receive treatment at MyOBGYN. In fact, I have the right to refuse to sign this authorization. When my information is used to 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 Officer at 81 Upper Riverdale Road, Suite 210, Riverdale GA, 30274.

Patient Signature _____ Date of Birth _____
(Patient or Authorized Signature)