

MARIETTA OB-GYN AFFILIATES, P.A.
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
Phone 770-422-8505 • Fax 770-424-7449

1. I hereby authorize _____ to disclose the following information from the health records of: _____

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone: _____
Pt. Number: _____

Covering the period(s) of healthcare:

From (date): _____ To (date): _____
From (date): _____ To (date): _____

2. Information to be disclosed **(please initial)**:

_____ Complete health records	_____ Discharge summary
_____ History and physical exam	_____ Progress notes
_____ Consultation reports	_____ Laboratory tests
_____ X-ray reports	_____ Photographs, videotapes, digital or other images
_____ Other (please specify): _____	

I understand this will include information relating to: **(please initial)**:

_____ Acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection
_____ Behavioral health service/psychiatric care
_____ Treatment for alcohol and/or drug abuse

3. This information is to be disclosed to: **Marietta OB-Gyn Affiliates, P.A.**
625 Church Street
Marietta, Georgia 30060 for the purpose of: _____

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

5. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ / _____
(Patient) Date

or (Legal Representative) (Relationship to Patient) Date

(Signature of Witness) Date