Marietta Ob-Gyn Affiliates, P.A.

Authorization to Disclose Medical Information

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Marietta Ob-Gyn Affiliates, PA to disclose the following medical information for the purpose of FMLA and/or Medical disability leave.

Information to be disclosed:

\_\_\_\_ Maternity records. Due Date or Date of Delivery \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Office notes and OP report pertaining to surgery. Date of surgery\_\_\_\_\_\_\_\_\_

This information is to be disclosed to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature date