

MARIETTA OB-GYN AFFILIATES, P.A.
699 Church Street • Suite 220 • Marietta, Georgia 30060
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
Phone 770-422-8505 • Fax 770-424-7449

1. I hereby authorize Marietta OB-Gyn Affiliates, P.A. 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):

_____ History and Physical exam	_____ Photographs, videotapes
_____ Consultation reports	_____ digital or other images
_____ X-ray reports	_____ Complete health records (This excludes HIV (AIDS),
_____ Progress notes	_____ Behavioral health and treatment for alcohol and/or
_____ Laboratory test	_____ drug abuse)
_____ Discharge summary	_____ 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: _____

_____ 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. The 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