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):**

______ History and Physical exam
______ Consultation reports
______ X-ray reports
______ Progress notes
______ Laboratory test
______ Discharge summary
______ Photographs, videotapes digital or other images
______ Complete health records (This excludes HIV (AIDS) Behavioral health and treatment for alcohol and/or drug abuse)
______ 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.**
699 Church Street, Suite 220
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. 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