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
purpose of: _____ for the

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