AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

Patient Name: _____________________ **Street Address**: ____________________________

City: _________________ **State**: __________ **Zip Code**: __________ **Date of Birth**: _________

Phone: ______-_________-____________

I hereby authorize Women's Health Associates
Phone: 404-252-3898 Fax: 404-843-0719
To:
[ ] release [ ] request my protected health information

RECIPIENT INFORMATION

Please **disclose** the following protected health information to: ___________________________

Street Address: _____________________________________

City: __________________________ **State**: ________________ **Zip Code**: __________________

Phone: _______-__________-__________ **Fax**: ________-___________-_____________

Please indicate the information or types of information to be disclosed, including dates if necessary *:*

____

This request is for the purpose of: ____

Appointment date for new provider (if applicable) _________________________________

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. **THIS INFORMATION WILL NOT BE RELEASED UNLESS YOU INDICATE; ______YOU MAY RELEASE INFORMATION (Indicate with a check mark).**

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with ChartPro Medical Records, for coping needs. I understand that I will be billed by ChartPro for the charges incurred in processing my request and agree to pay all charges in full. Please direct calls to **ChartPro** at **770-884-8199 or 770-434-0042**.

____ ________/__________/_________

Signature of patient or Authorized Representative **Date**

If this document is signed by anyone other than the patient the appropriate corresponding paperwork must be submitted with this request