OB-GYN ASSOCIATES, PA

699 Church Street, Suite 300

Marietta, GA 30060

Date ___/___/_____

Patient Name (please print) _____

Patient Date of Birth ____/____/_____

Patient Social Security Number xxx - xx - _____

Patient Phone Number (____) _____ - _____

I authorize OB-GYN Associates, PA to (choose one):

☐ RECEIVE RECORDS FROM _____

Address_____

_____

Phone Number (___) ____ - _____

Fax Number (___) ____ - _____

☐ RELEASE RECORDS TO _____

Address_____

_____

Phone Number (___) ____ - _____

Fax Number (___) ____ - _____

ALL INFORMATION MUST BE COMPLETED

Information Requested:

_____ MOST RECENT INFORMATION _____ OTHER (specify) _____

_____ ENTIRE CHART _____

_____

Do you want to pick up records? _____

Are you leaving the practice? _____ If yes, reason: _____

Do you have an upcoming appointment? _____ When? ____/____/_____

PATIENT SIGNATURE _____

This authorization will expire in six months or on _____/_____/_____

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPAA Privacy Rule. I have the right to revoke this authorization in writing, except (i) to the extent the Practice has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Privacy Official at 699 Church Street, suite 300 Marietta, GA 30060, by sending a written request stating that wish to revoke this Authorization to the attention of the Privacy Official.

I understand that the Practice may not condition treatment, payment, enrollment of eligibility for benefits on whether I sign this Authorization.

_____ _____

Print Patient Name Patient Signature Date

_____

Patient Mailing Address Patient Phone Number

_____ _____

Patient Social Security Number Patient Date of Birth

Please mail completed form to OB/GYN Associates, PA 699 Church Street, suite 300 Marietta, GA 30060 or Fax to (770) 425-7601 – Attn: Medical Records Dept. Please note that this may take up to 7-10 days to process after receiving the form.