

Dunwoody Obstetrics & Gynecology, P.C.

Medical Records Release Form

Patient Name: _____ Soc. Sec. #: _____

Address: _____ Date of Birth: _____

By signing this authorization form, I authorize Dunwoody Obstetrics & Gynecology, P.C. to use and/or disclose certain protected health information (PHI) about me. I authorize you to release confidential health information about me, to the person(s) or entity listed below.

Please send my protected health information to the following person(s)/entity:

Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

My authorization extends or is limited to: please check all that apply

Records of my visits or specific dates: from _____ to _____.

Patient History

Progress Notes

Diagnostic Reports

Consultation Reports

Statement of Charges and Payments

All of the above

Other: please specify _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or electronic format, are confidential and cannot be disclosed without my prior written authorization, except as provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released.
4. Treatment, payment and operation of our business may not be conditioned upon this authorization.
5. The release of information authorized may be subject to re-disclosure by the recipient.

This authorization will expire on _____

Patient Signature (or parent, guardian or legal representative)

Date

Printed Name