



Classic City OB/GYN, LLC
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Providing Compassionate, Quality Healthcare for Women

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AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION AT THE REQUEST OF THE PATIENT/PATIENT REPRESENTATIVE

At the request of _____ (patient/patient representative), this document authorizes Classic City OB/GYN, LLC to disclose / obtain (circle one) protected health information from the records of _____ (patient name), _____ DOB, to / from (circle one) _____ (hospital/physician/self/other), _____ (address and/or fax number)

I agree that any and all health information may be disclosed, including but not limited to mental health, drug or alcohol use, HIV/AIDS test results and any other records protected by state or federal laws. OR...

I request that release of protected health information be restricted to the following portions of the medical record:

Three horizontal lines for specifying portions of the medical record.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice at 740 Prince Ave, Bldg 2, Athens, GA 30606.

I understand this authorization ends on _____ (date).

Patient/Patient Representative Signature Date

Signature of Witness Date

Patient Representative:
Parent/Guardian of Minor Patient
Guardian/Conservator
Next of Kin/Executor of Deceased