

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
****Medical Records Fax Number 706-549-1106****

Patient: _____ Birthdate: _____

Address: _____

Phone: () _____ SS# _____

I authorize Classic City OBGYN, LLC to
(choose one of the following)

RELEASE records to: _____

(name, address, phone # and fax #)

OBTAIN records from: _____

(name, address, phone # and fax #)

Indicate reason for request:

- Transferring care to another provider
- Obtaining second opinion
- Physician referral

_____ 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:

_____ 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
 1500 Oglethorpe Avenue, Suite 200C, 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