

Atlanta Gynecology & Obstetrics, P.C. Records Release

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Decatur, GA 30030
Telephone (404) 299-9724
Fax (404) 299-0382

449 Pleasant Hill Road, Suite 200
Lilburn, GA 30047
Telephone (770) 923-5033
Fax (770) 279-2769

Patient Name	
Date of Birth (mm/dd/yy)	
Last 4 of SSN	

The Atlanta Gynecology and Obstetrics Practice identified above is hereby authorized to **(Please mark appropriate box, 1 or 2):**

1) Release **TO** **OR** 2) Receive **FROM** the following:

Doctor/Hospital/Patient	
Street/Suite #	
City/State/Zip	
Phone #	
Fax #	

(Check all applicable)

- | | |
|---|--|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Chart Summary |
| <input type="checkbox"/> Laboratory/pathology records | <input type="checkbox"/> Pharmacy/prescription records |
| <input type="checkbox"/> X-ray/radiology records | <input type="checkbox"/> Other (describe specifically) _____ |
| <input type="checkbox"/> Billing Records | |

For the following date of service: _____

Unless you state otherwise, this authorization includes the release of all medical records and information, except as otherwise noted below. This authorization includes any records regarding **drug, alcohol, or psychological or psychiatric conditions, including psychotherapy notes** to the person(s) listed above.

Unless you state otherwise by marking one or both boxes below, this authorization includes the release and disclosure of **STD results, HIV/AIDS testing**, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., included herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

I **object** to the release of **STD/HIV/AIDS** confidential information.

I **object** to the release of any **psychological or psychiatric conditions, including psychotherapy notes** under Georgia law.

For the purpose of: Further Medical Care Insurance Billing Legal Reasons Self
 Other (Please Specify) _____

Patient Signature: _____

Date: _____