Atlanta Gynecology & Obstetrics, P.C.
Medical Records Authorization and Release

☐ 315 Winn Way
Decatur, GA 30030
Phone: (404) 299-9724
Fax: (404) 299-0382

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

Patient Name		Date of Birth	
Address			
Phone #			

Our practice, identified above, is hereby authorized to:
1) ☐ Release records **TO** the following**:** **OR** 2) ☐ Receive records **FROM** the following:

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

(Check all applicable)

☐ All Records
☐ Laboratory/pathology records
☐ X-ray/radiology records
☐ Billing Records
☐ Chart Summary
☐ Pharmacy/prescription records
☐ Other (Specify Clearly): _____

For the following dates of service: **from** _____ **to** _____

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

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Unless you state otherwise, this authorization includes releasing all medical records and information, except as otherwise noted below. This authorization includes any documents 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 disclosing these test results to anyone.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., included herpes, herpes simplex, human papillomavirus, 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.

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I understand this authorization will expire five years from the date on which I signed this form. This authorization can be revoked by submitting a written request to Atlanta GYN & OB. The revocation will not apply to any information already released.

Patient Signature: _____ Date: _____
Guardian Signature (if applicable): _____ Date: _____