Thomas H. Moseley, Jr., MD
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I ____ DOB: ______________________
Patient Name

Phone Number: ______________________ Last Four of Social Security Number: ________________

Authorize my protected Health Information to be released:

☐ **From** ☐ **To** Southern OB/GYN Associates
220 Northside Drive
Valdosta, Georgia 31602
Fax: (229) 245-0888 Phone: (229) 241-2800

☐ **From** ☐ **To** ______________________________
____
____
Fax : (____) _____-_______ Phone: (____) ____-______

Please indicate if you want your records: ☐ Faxed ☐ Mail (mailing fee $5.00) ☐ Pick up

For the purpose of: ☐ Moving ☐ Transfer of Care ☐ Referring Physician ☐ Attorney ☐ Insurance
☐ Personal ☐ **Verbal Exchange (I give permission for the above referenced person to speak with Southern OB/GYN Physician/Staff regarding my Protected Health Care Information)**

Copy Fees: ☐ 10 pages or less no charge ☐ 11-25 pages $10.00 ☐ 26 pages and up $20.00 ☐ Mailing Fee $5.00

☐ Storage retrieval fee $ 25.00 + applicable copy fees

Specific Information Requested:

☐ Progress / Office Notes — Specific Dates Requested ______________________
☐ Current Pregnancy Records — Specific Dates Requested ______________________
☐ Laboratory Reports — Specific Dates Requested ______________________
☐ Surgery Reports including Pathology's — Specific Dates Requested ______________________
☐ Radiology / Mammography CD's & Reports — Specific Dates Requested ______________________
☐ Other - ____________________ — Specific Dates Requested ______________________
☐ **ALL Records**

I place no limitations on history regarding all matters relating to diagnosis, care and treatment of alcohol, drug abuse, abortions, sexually transmitted diseases, HIV, AIDS, or psychiatric disorders.

I understand I do not have to sign this authorization in order to get health care benefits and that I may revoke this authorization in writing. I also understand that such revocation would not affect any actions already taken by Southern OB/GYN based upon this authorization and that I may not be able to revoke this authorization if its purpose was to obtain insurance. Furthermore I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

This authorization is valid for ONE YEAR from the date of signature.

______________________________ ______________________________
Patient/Guardian/Legal Representative — Date

______________________________ ______________________________
Printed name if signed on behalf of the patient — Relationship (parent, legal guardian, personal representative)
Legal documentation required.

______________________________ ______________________________
Employee Witness — Date