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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

COPY FEES MAY APPLY

Patient Information	Name: ____________________ Date of Birth ____________ Last 4 digits of SS# __________ Phone Number ______________ Address: ______________________________ City: ____________________ State: ______ Zip: __________
Release From (Who has the information you want released? *Please list the specific Hospital /Doctor and /or Clinic)	□ Southern OB/GYN Associates 220 Northside Dr. Valdosta, GA 31602 Fax 229-245-0888 Phone: 229-241-2800 □ Name: ________________ Address: ________________ City: ______State: _____ Zip: ______ Phone: ________________ Fax: ________________
Send To (Where and to whom do you want the records sent? *Please list the specific Hospital /Doctor and /or Clinic)	□ Me □ Southern OB/GYN Associates 220 Northside Dr. Valdosta, GA 31602 Fax 229-245-0888 Phone: 229-241-2800 □ Name: ________________ Address: ________________ City: ______State: _____ Zip: ______ Phone ________ Fax ________
Verbal Exchange I authorize this individual to speak with Southern OB/GYN Associates (Doctors and staff) regarding my protected health information	Name: ______________________________ Address: ______________________________ City: ____________________ State: __________ Phone # ______________________________
Information to be released (What do you want? Check the appropriate boxes)	□ Office notes □ Laboratory Reports □ Radiology □ Surgery with Pathology □ Current Pregnancy □ Last 2 years □ Mammogram/Ultrasound Images on CD □ Other ______________________________ **Date(s) of service** ______________________________
Release Instructions (How and When do you want the information?)	Date information is needed: __________ (Note please allow 30 days for processing) **Release Method:** □ Mail - Address: ______________________________ □ Pick up - Who will be picking up records ____________________ □ Fax Number: ______________ Attention: ______________ □ Secure e-mail - Address: ______________________________ □ Other ______________________________
Purpose of Release (please check all that apply)	□ Moving □ Transfer of Care □ Attorney □ Insurance □ Personal □ Referring Physician □ Other ______________________________

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. If I am a current obstetrical patient as of 10/1/20, I authorize the exchange of my medical records from the date of transfer through the end of my pregnancy back to Southern OB-GYN Associates, PC for clinical and billing purposes.

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