Release of Records

**All information must be filled out completely or request will be denied.*

Date_____ / _____ / _____
Patient Name (please print) _____
Patient Date of Birth_____ / _____ / _____
Patient Social Security Number xxx-xx-_____
Patient Phone Number (_____) _____ - _____

I authorize OB-GYN Associates, P.A. to (choose one):

O RECEIVE RECORDS FROM _____
Address _____
_____
Phone Number (_____) _____ - _____
Fax Number (_____) _____ - _____
ALL INFORMATION MUST BE COMPLETED

O RELEASE RECORDS TO _____
Address _____
_____
Phone Number (_____) _____ - _____
Fax Number (_____) _____ - _____
ALL INFORMATION MUST BE COMPLETED

Information Requested

___ MOST RECENT INFORMATION ___ OTHER (SPECIFY) _____
___ ENTIRE CHART _____
_____

Do you want to pick up records?_____
Are you leaving the practice? _____ If yes, reason: _____
Do you have an upcoming appointment _____When? _____ / _____ / _____

Patient Signature _____

This authorization will expire in six months or on _____ / _____ / _____
I understand that when my PHI is disclosed pursuant to this Authorization, It may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (I) to the extent the Practice has acted in reliance upon this Authorization; (II) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the Insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Privacy Official at 699 Church Street, Suite 300, Marietta, Georgia 30060, by sending a written request stating that wish revoke this Authorization to the attention of the Privacy Official.

I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

_____	_____
Print patients name	Signature Date
_____	_____
Patient mailing address	Patient Phone Number
_____	_____
Patient social security number	Patient date of birth

Please mail completed form to OB/GYN Associates 699 Church Street, Suite 300, Marietta, GA 30060 or fax to (770) 425-7601.
Our office will call if charges applied. Note this will take up to 7 - 10 days to process after receiving the form.

OB-GYN ASSOCIATES, PA
699 CHURCH STREET
SUITE 300
MARIETTA, GEORGIA 30060
TEL.770/422-8700 FAX.770/425-7601

Release of information for OBGYN ASSOCIATES is managed by HealthPort.

To assist in properly handling your request for medical information, **please fill out the entire authorization form.** All authorizations must be signed and dated by the patient unless the patient is a minor child, deceased, physically and/or mentally impaired or has an appointed attorney/legal guardian over healthcare. A copy of the Power of Attorney, guardianship papers, death certificate, and/or executor papers must accompany the request. **Due to State and Federal Laws, no exceptions will be made.**

There is a state mandated fee for copies of medical records. State of Georgia Fee Schedule Chapter 323 of Title 31 of the Official Code of Georgia Annotated, Section 2-A.

.96 per page (page 1-20)
.83 per page (pages 21-100)
.66 per page (all pages over 100)
Plus the actual cost of postage

Records will be mailed only to the destination of the request. You will receive an invoice from Healthport.

By signing below, I acknowledge that I have read the above procedures regarding the release of medical records.

_____ _____
Patient Signature Date