ROSWELL OBSTETRICS AND GYNECOLOGY, LLC

REQUEST/RELEASE OF MEDICAL INFORMATION

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Fax 770-751-3615

5780 Peachtree Dunwoody Rd., NE
Suite 195
Atlanta, GA 30342
Fax 770-399-2803

684 Sixes Rd.
Suite 235
Holly Springs, GA 30115
Fax 770-924-2896

1800 Northside Forsyth Dr.
Suite 260
Cumming, GA 30041
Fax 678-845-2839

Patient's name:

Date of Birth: / /

RELEASE FROM:

Name:
Address:
City, State/Zip:

Phone: ( ) _

Fax: ( )

RELEASE TO:

Name:

Address:

City, State/Zip:

Phone: ( ) _

Fax: ( )

INFORMATION TO BE REQUESTED/RELEASED

Specify date or time period for information requested:

- History & Physical/Office Notes
- Lab Reports
- Operative Reports
- Pathology Reports
- Prenatal Records, All
- Ultrasounds/Mammogram Reports

Roswell OBGYN and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

SPECIFIC AUTHORIZATIONS

Purpose of release/request [check any that apply]:

Continuity of care or discharge planning (transfer of care)
Billing and payment of bill
At request of patient or patient's legal representative
Other (reason): _

I specifically authorize the release of information pertaining to:

Drug and alcohol abuse, diagnosis, and treatment Mental health diagnosis and treatment
DS testing
c testing information

NOTICE OF MY RIGHTS

I understand this authorization is voluntary. Treatment, payment enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility

or enrollment in a health plan, for determining an entity's obligation to pay a claim, or creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of information of mental health records.

I may revoke this authorization at any time, provided that I do so in writing and submit it to AWHG c/o Health Information Management, 6285 Barfield Road Atlanta, Georgia 30328. The revocation will take effect when AWHG receives it, except to the extent that I am entitled to receive a copy of the authorization.

Unless otherwise revoked, this authorization expires *. If no date is indicated, this authorization will expire in 12 months.*

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(If the patient is a minor or being legally represented please put parent/guardian information below.)

Print name: Date:

Signature:

Please fax records to: "ATTN: MEDICAL RECORDS"

Alpharetta(770) 751-3615 **Interchange(770) 399-2803**

Holly Springs (770) 924-2896 **Cumming (678)845-2839**