ROSWELL OBSTETRICS AND GYNECOLOGY, LLC

 **REQUEST/RELEASE OF MEDICAL INFORMATION**

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Alpharetta, GA 30022 Atlanta, GA 30342 Canton, GA 30115 Cumming, GA 30041

Fax 770-751-3615 Fax 770-399-2803 Fax 470-378-2709 Fax 770-781-4770

## Patient’s name: Date of Birth: / /

**RELEASE FROM: RELEASE TO:**

Name: Address: City, State/Zip:

Name: Address: City, State/Zip:

Phone: ( ) \_ Phone: ( ) \_

Fax: ( )

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

HIV/AIDS testing

Genetic 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.*

(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 Northside Interchange 770/399-2803**

**Canton 470/378-2709 Cumming 770/781-4770**