Arbor OBGYN Women's Care, LLC
4360 Chamblee-Dunwoody Rd, Ste. #370
Atlanta, GA 30341
Tel: (770)399-5055 Fax: (770)399-9638

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please check:

- ☐ Release TO Arbor OB/GYN: I authorize (place provider's name and office phone number here) _____ to release, disclose, and/or provide protected health information (PMI) to Arbor OB/GYN Women's Care, LLC.
- ☐ Release FROM Arbor OB/GYN: I authorize Arbor OB/GYN Women's Care, LLC to release, disclose, and/or provide protected health information (PMI) to (place provider's name and office number here) _____.

This authorization permits the release of my protected health information specifically as described in the space below. This authorization will expire 30 days from the date of my signature below.

Please release:

- ☐ All my medical records
- ☐ Only my prenatal records
- ☐ Only last notes and labs
- ☐ A copy of my records to me
- ☐ Other (please describe): _____
  _____
- ☐ If there are records you specifically do NOT want released, list them here: _____
  _____

I do not have to sign this authorization to receive treatment from Arbor OB/GYN. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization. My written revocation must be submitted to the Privacy Officer at: 4360 Chamblee Dunwoody Road, Suite 370 Atlanta, GA 30341.

_____ Signature of Patient

_____ Signature of Witness

_____ Name (please print)

_____ Date of Birth

_____ Date

_____ Social Security Number