Haven Ob/Gyn

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize (place other provider here) _____ to release, disclose, and/or provide protected health information (PMI) to/from Haven Ob/Gyn, LLC. 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

□ Please release only my prenatal records

□ Please release a copy of my records to me

Please release only my:
_____Labs
_____Radiographic Studies
_____Progress Notes and Office Visits
_____Other (please specify) _____

Contact information for other office (Name, address, phone, fax):
_____
_____
_____
_____
_____
_____

The purpose of my releasing this information is to continue my medical care with Haven Ob/Gyn. Any delay in sending this information may cause a delay in the administration of proper and necessary medical care. Thank you kindly for your assistance.

Please fax the information (unless otherwise specified) to the fax number at the top of this authorization and again here: **FAX (770) 399-5726**

_____ Signature of Patient

_____ Signature of Witness

_____ Name (please print)

_____ Social Security Number

_____ Date of Birth

_____ Today's Date