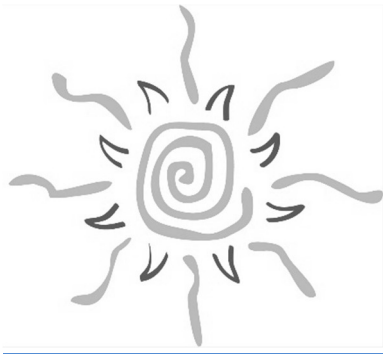




Haven Ob/Gyn

4360 Chamblee-Dunwoody Rd
Suite 370
Atlanta, GA 30341
P 770-393-1988 F 770-399-5726

Brad Moore, MD
Bryan Jewell, MD
Lina Tibavinsky Bernal, MD
Leah Pombo, NP

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please check:

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