AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Request for records from an Outside Facility

Patient Name: ______________________**Street Address**: ________________________________

City: _______________________**State**:_______ **Zip Code**: _________ **Date of Birth**:_________

Patient's Phone:__________________________ **Social Security Number:**___________________

To: ____

Phone: _______________________ Fax: _____________________

I hereby authorize the above physician or medical facility to disclose my health information as directed below.

RECIPIENT INFORMATION

Please disclose the following protected health information to:

North Pointe OB/GYN Associates, LLC
Attn: Incoming Medical Records
1800 Northside Forsyth Drive, Suite #350
Cumming, GA 30041
770-886-3555/ph; 678-807-6050/efax (Preferred method of receipt)

Please indicate the information or types of information to be disclosed:

____

Specify Dates (or date ranges) if necessary: ____

This request is for the purpose of: ____

These records are needed no later than: ____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in **six months** or on this date listed ________________.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE; ____ DO NOT RELEASE (Indicate with a check mark).

____ ____________________________
Signature of Patient or Authorized Representative Date

____ ____________________________
Representative's Authority to Act on Behalf of Patient Signature of Witness