Greater Atlanta Women's Healthcare

Obstetrics & Gynecology

550 Peachtree Street • Suite 1470 • Atlanta, Georgia 30308-2242

(404) 589-2670 • Fax (404) 589-2671

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I, ____, authorize and request
(Print Name)

GREATER ATLANTA WOMEN'S HEALTHCARE 550 Peachtree Street, N.E., Suite 1470, Atlanta, GA

TO RELEASE: **(Please Check all that apply)**

☐ Office Notes	☐ Pathology Reports
☐ Lab Reports	☐ Pap smear Reports
☐ Ultrasound Reports	☐ Mammogram Reports
☐ Ob Reports	☐ All Records
☐ Physical Reports	☐ Other________________________

TO:

Physician Name:______________________________________

Address: ______________________________________

Phone Number: ______________________________________

Fax Number: ______________________________________

Reason for Release: ____

Medical Records Copying Charges

The Georgia Office of Planning and Budget (OPB) pursuant to O.C.G.A. 31-33-3, calculates an annual inflation adjustment for the costs related to medical record retrieval, certification and copying, Payment for all requested information is due prior to release/disclosure. Fees for requested information are as follows:

- $25.88 for the search, retrieval and administrative costs related to the request for documents.
- Copy pages 1 – 20 $.97 ea., Pages 21-100 $.83 ea., Pages 100 and up $.63 ea.
- $9.70 for certifying records.

If you need a copy of the requested information for personal use, the above charges will apply. If you need the requested information sent **to a physicians' office, as a courtesy to the physician, we will send the requested information at no charge.**

I am aware that some of the health care information or other information contained in the requested medical records may be confidential or privilege and I hereby specifically waive any privilege or confidentiality existing under federal or state regarding such information including, but not limited to, protection afforded to:

(1) AIDS and HIV Confidential Information
(2) Medical Information Concerning Alcohol and Drug Abuse
(3) Medical Information Regarding Mental Illness
(4) Communications Made to Licensed Applied Psychologist
(5) Medical Information
(6) Medical Information Concerning Alcohol & Drug Dependency
(7) Communications made to Psychiatrist
(8) Medical Information Concerning Mental Retardation

This authorization and consent is subject to revocation at any time, except to the extent that action has already been taken in reliance on it. If not previously revoked, this authorization will terminate 90 days from the date appearing below.

Patient Name: ______________________ **Birth Date**______________ **SSN#**__________

Signature: ____
(Patient or Authorized Person) (Date)

Witness Signature: ______________________________

NOTE TO RECIPIENT: The Information That Has Been Disclosed To You Is Or May Be Protected By State and Federal Laws. You Are prohibited From making Any Further Disclosure Of This Information Unless Further Authorization Is Obtained Or Disclosure Is Otherwise Permitted By Law. A General Authorization For Release Of Information May Not Be Sufficient.