Greater Atlanta Women's Healthcare
550 Peachtree Street, N.E., Suite 1470, Atlanta, GA 30308
Phone (404) 589-2670 | MEDICAL RECORDS FAX (404) 795-0954

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I, _____, authorize and request
(Patient Name)

Greater Atlanta Women's Healthcare | 550 Peachtree St NE Suite 1470 Atlanta Georgia 30308

TO RELEASE: (please check all that apply)

- ☐ Office Notes
- ☐ Lab Results
- ☐ Ultrasound Reports
- ☐ Obstetrical Reports
- ☐ Physical Reports
- ☐ Pathology Reports
- ☐ Pap smear Reports
- ☐ Mammogram Reports
- ☐ All Records
- ☐ Other _____

TO: Physician Name: _____

Address _____

Phone Number: _____

Fax Number: _____

Reason for Release:_____

Is the Patient Transferring Medical Care ☐ YES ☐ NO

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

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:

- S25.88 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 S.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 or healthcare facility, as a courtesy, we will send the requested information at no charge.

This authorization and consent is subject to revocation at anytime, 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: _____ Date of Birth _____ Last 4 SSN_____
(Print)

Signature: _____ _____
(Patient or Authorized Person) DATE

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.