



401 South Main St. Suite B-8, Alpharetta, GA, 30009 (p) 770-521-2229 (f) 770-521-2231

Authorization for Disclosure of Health Information

Patient Name: _____ D.O.B _____

Phone Number: _____

I understand this information will be disclosed to or obtained from:

Name: _____ Phone: _____

Address: _____ City/ State/ Zip: _____

Purpose for need of disclosure: (check applicable categories)

- Further Medical Care Personal- At the request of the individual
 Insurance Eligibility/ Benefits Changing physicians
 Legal Investigation or Action Other (Specify): _____

Information to be released Entire Record only the parts of the medical record I specify

Ultrasounds Pap smear OB records Labs other: _____

This protected health information is being used/ disclosed to carry out treatment, payment, and/ or health care operations of Isis OB/GYN, LLC in the following manner: **Continuity of Care**

This authorization shall be in force and effect until: 1) 90 days from the date of this request **OR** 2.) Such time at which the requested information is no longer clinically relevant.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office manager at the above address. I understand that a revocation is not effective to the extent that Isis OB/GYN, LLC has relied on the use or disclosure of protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Isis OB/GYN, LLC will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provided authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

Signature of Patient: _____ Date: _____