2905 Jordan Court, Suite G
Alpharetta, GA 30005
678 335 9223

# AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT:_________________________________DOB:_________________________

From: Alpha OB/GYN
2905 Jordan Ct. Ste G
Alpharetta, GA 30004
P:678-335-9223 F:678-335-9236

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying Alpha OBGYN in writing.

**PLEASE SEND A COPY OF MY MEDICAL RECORD TO:**

Facility/Doctor/Self:
_____________________________________________________

Fax: ____________________________
Phone:______________________________

Information Needed:

_________Operative Notes(s)

_________Office Records

_________Prenatal record, including laboratory and ultrasound reports, from the current pregnancy

________Lab and/or radiology reports

________ Other_____________________________________________________

_____________________________________________________________
**Signature of patient or patient's representative** **Date signed**

*This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and protected by state and federal law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, forwarding, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by e-mail or telephone, and delete the original message immediately. Thank you.*