Date Received:_____ **Chart #:**_____

SOUTHERN CRESCENT WOMEN'S HEALTHCARE, P.C.
1279 Hwy. 54 West, Suite 220
Fayetteville, GA 30214
Phone: (770) 991-2200 / Fax: (770) 716-8672

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I, _____, authorize and request:

FROM: **SOUTHERN CRESCENT WOMEN'S HEALTHCARE, P.C.**

To Release:

❑	Office Notes	❑	Physical Reports
❑	Lab Reports	❑	Pathology Reports
❑	Ultrasound Reports	❑	Mammogram Reports
❑	Ob Reports	❑	Pap smear Reports
❑	All Records	❑	Other_____

To: _____
Name of Physician or Office **Fax**

_____
Address **City** **State** **Zip** **Phone**

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 information in the requested Medical Records may be of a sensitive nature. By signing this release, I am granting permission for the information pertaining to the below mentioned areas to be released. I waive any privilege or confidentiality existing under Federal or State Law regarding such information, including, but not limited to, protection afforded to:

(1) Communications made to Psychiatrist (O.C.G.A. 24-9-21)
(2) Communications made to a Licensed Applied Psychologist (O.C.G.A. 43-36-16)
(3) Medical Information concerning drug dependency (O.C.G.A. 26-5-17)
(4) Medical Information concerning alcohol and drug dependency (O.C.G.A. 37-1-166)
(5) Medical Information regarding mental illness (O.C.G.A. 37-3-166)
(6) Medical Information concerning mental retardation (O.C.G.A. 37-4-126)
(7) Medical Information concerning alcohol and drug abuse (42-C.F.R. Part 2)
(8) AIDS confidential information (O.C.G.A. 31-22-9 and 24-9-47)

This Authorization and Consent is in effect for 90 days. Our Office will act on this release within 7-10 business days of receipt. The Authorization will terminate 90 days from the date appearing below.

Patient Name: _____ **Birth date:** _____ **SSN#:** _____

Signature: _____ **Date:** _____
Patient or Authorized Person

Witness Signature: _____ **Date:** _____

Note to Recipient: The information that has been disclosed to you is or may be protected by State and Federal Law. 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.