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

1. Patient Name ______________________________ **Patient DOB** ________________

I, ____, authorize and request that my protected health information be disclosed by:

____
Name of Physician or Office **Fax**

____
Address **City** **State** **Zip** **Phone**

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

2. Specific description of information to be disclosed: (*please check all that apply*)

To Release:

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

3. Specific purpose for the disclosure: ____

____

4. Important Information About Your Rights

By signing below, you understand that:

- This authorization is voluntary and you may refuse to sign it.
- You may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to the disclosing healthcare provider, at the address listed above. The revocation will apply to future disclosure of your information, but it will not have any effect on any actions that the disclosing healthcare provider took before it received the revocation notice.
- You are not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan, or establishing eligibility for benefits.

- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving person or organization and, upon re-disclosure, will no longer be protected by federal privacy laws, including but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
- You will be given a copy of this signed authorization.

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.

Some of the information in the requested Medical Records may be of a sensitive nature. By signing this release, you are granting permission for the information pertaining to the below mentioned areas to be released. You hereby 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)

5. Signature of Patient or Personal Representative

This authorization will expire 90 days after the date of the signature below. Our Office will act on this release within 7-10 business days of receipt.

Patient or Personal Representative Signature: ______________________________

Date: ____________________

If the form is signed by the patient's personal representative, complete the following information:

Printed name of the patient's personal representative: ______________________________

Relationship to the patient, including authority to act as personal representative:

____

____