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993-C Johnson Ferry Road
Suite 120
Atlanta, GA 30342

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Alpharetta, GA 30005

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER

I authorize the use and/or disclosure of my Protected Health Information **("PHI")** as described below:

1. I authorize:

NAME

MAILING ADDRESS

CITY/STATE/ZIP

to release the information described below. Only this information may be used and/or disclosed pursuant to this Authorization:

2. I authorize the following persons (or class of persons) to receive my **PHI**:

NAME | NAME

MAILING ADDRESS | MAILING ADDRESS

CITY/STATE/ZIP | CITY/STATE/ZIP

3. I understand that, if my **PHI** is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

4. I understand the following Notice will appear in the disclosure of my **PHI** to the above recipient(s): the attached medical information pertaining to _____ (patient) is confidential and legally privileged. Northside OB/GYN, P.C. has provided **said PHI** to _____ ***as authorized by the patient. The recipient may not further disclose the PHI without the express written(?) consent of the patient or as authorized by law.***

5. I understand that I have the right to revoke this Authorization at **any time**. My revocation must be in writing, addressed to Northside OB/GYN, P.C. 993-C Johnson Ferry Road, Suite 120, Atlanta, GA 30342. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my **PHI** have acted in reliance upon this Authorization.

6. If the patient is a minor (under 18 years **of age**) or incapacitated, **this** Authorization must be signed by a parent or legal guardian. If **the** parent is deceased, **the** next of kin, executor or estate must sign **this** Authorization.

7. This Authorization expires on: _____.

PATIENT/LEGAL REPRESENTATIVE'S SIGNATURE | RELATIONSHIP TO PATIENT | DATE