



ALAN L. JOFFE, MD, F.A.C.O.G.
 Diplomat, American Board of Obstetrics and Gynecology
NORTHSIDE OB/GYN, P.C.
 Telephone: 404.256.2811
 Facsimile 404.257.9855
 993-C Johnson Ferry Road Suite 120 Atlanta, GA 30342
 3400-A Old Milton Parkway Suite 200 Alpharetta, GA 30005

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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I authorize the use and/or disclosure of my Protected Health Information (“PHI”) as described below:

- 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:

- 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

- 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.
- 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.
- 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.
- 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.
- This Authorization expires on: _____.

PATIENT/LEGAL REPRESENTATIVE'S SIGNATURE	RELATIONSHIP TO PATIENT	DATE
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