



Arbor Obstetrics and Gynecology, P.C.
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**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize Arbor OB/GYN to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Arbor OB/GYN to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates of service, level of detail to be released, origin of information, etc.)

The information will be used or disclosed for the following purpose:

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

Arbor Ob/Gyn(circle one): **will** **will not** receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Arbor OB/GYN. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization. My written revocation must be submitted to the Privacy Officer at: 9 Dunwoody Park, Suite #108, Atlanta GA 30338.

Signature of Patient

Signature of Witness

Name (please print)

Date of Birth

Date

S.S.N.