Arbor Obstetrics and Gynecology, P.C.
9 Dunwoody Park, Suite 108
Atlanta, Georgia 30338
Tel: 770-399-5055 Fax: 770-399-9638

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize ________________________________to Use and disclose certain health information (PHI) about me to Arbor OB/GYN. This authorization permits __________________________________ to use and/or disclose the following individually identifiable health information about me. (please choose records requested)

[] **All records** [] **All prenatal records** [] **Last notes and Labs**

[] **Other** (please describe records requested) ________________________________
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This authorization will expire in 30 days.

When my information is used or disclosed pursuant to this information, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy rule.

_________________________	_________________________
Name of patient	Signature of witness
_________________________	_________________________
Signature of Patient	Date
_________________________	_________________________
Date of birth	SSN

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Name and number of office with requested records.