GEORGIA OBSTETRICS AND GYNECOLOGY

A DIVISION OF ATLANTA WOMEN'S HEALTH GROUP, P.C.

J. Kel Harper, M.D. Nicole Pasteur, M.D.
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Informed Authorization and Consent for the release of Medical Records

I, _____ (Print Name), born on _____/_____/_____ (mm/dd/yyyy) hereby authorize Georgia OB/GYN to:

( ) Release to ( )Obtain from:

_____
Name/Company/Office

_____
Address/City/Zip

_____
Phone & Fax

for the purpose of: _____

Please indicate what specifically is to be released:

( ) Entire Medical Record	( ) Mammography	( ) Laboratory Tests
( ) Discharge Summary	( ) Operative Reports	( ) Pathology

( ) Other: _____

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing, and/or HIV/ARC testing, I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. This authorization/consent will remain in effect for a period of one (1) year from the date stated below, unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian or legally authorized agent), to the Medical Records Department. These medical records are being disclosed under the provisions of the applicable New Jersey State and Federal Law.

NOTICE TO THE RECEPIENT OF RECORDS:
The information has been disclosed to you from records protected by Federal Laws of confidentiality (42 C.F.R. Part 2). These laws prohibit you from making any further disclosure of these records, unless further disclosure is expressly permitted by written authorization by the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of these medical records is not sufficient for this purpose. You may only use these medical records for the purpose(s) as stated above.

X_____ _____
Patient, Parent, Legal Guardian/Agent Date