Phoenix Women's Center, P.C.

1720 Phoenix Blvd. - Suite 700
College Park, Georgia 30349
Office: 404-446-4792
Fax: 404-446-4796

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

DATE:

PATIENT NAME: _____

Date of Birth: _____ **Patient Phone**: _____

Purpose or need for information: _____

I hereby authorize Phoenix Women's Center, P.C. to: **RELEASE or OBTAIN**

the protected health information regarding the above named person to/from:

Institution/Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ **Fax**: _____

Types of Records

- ☐ History and Physical
- ☐ Progress Notes
- ☐ Lab reports
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other _____

PROHIBITATION ON RE-DISCLOSURE: Information that has been disclosed to you is or may be protected by State and Federal Law. You are prohibited from making any farther disclosure of this information unless further authorization is obtained or disclosure is otherwise permitted by law. A general authorization for release of information may not be sufficient.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulation. I am aware that some of the information in this request for medical records may be of a sensitive nature. By signing this release, I am granting my permission for the information pertaining to the above mentioned areas to be released.

Signed: _____ **Witness**: _____

(Patient or Legal Guardian)

_____

(Relationship to Patient)

Please allow 5-7 business days to complete this request. We cannot release hospital records or records from other physicians. All records requested are subject to a processing fee; however, records can be faxed to another physician's office without charge.

Please fax records being released to Phoenix Women's Center to **(404) 446-4796.**