

MERIDIAN OB/GYN RELEASE OF INFORMATION AUTHORIZATION FORM

Section A: This section to be completed by the patient.

Patient Name:		Date of Birth:			
Address:		Phone Number:			
		Other:			
Name of Disclosing Hospital/Provider	Facility Name:				
	City/State/Zip:				
	Phone :				
Name of Recipient	Requestor Name :	Valisia A. Andrews,MD			
	Address:	4056 Wetherburn Way Suite 200			
	City/State/Zip:	Norcross, GA 30092			
	Phone:	770-723-9318 Fax: 770-838-7161			
Date(s) of Service:					
List specific description of information to be released:	<input type="checkbox"/> Anesthesia <input type="checkbox"/> Billing Records <input type="checkbox"/> UB04 <input type="checkbox"/> Itemized Bills <input type="checkbox"/> Consultation	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> EKG's <input type="checkbox"/> Emergency Records <input type="checkbox"/> Face Sheet <input type="checkbox"/> History & Physical	<input type="checkbox"/> Imaging Reports <input type="checkbox"/> Laboratory <input type="checkbox"/> Medication Records <input type="checkbox"/> Nursing Records <input type="checkbox"/> Sgy/Proc Report	<input type="checkbox"/> Physician Orders <input type="checkbox"/> Outpatient Records <input type="checkbox"/> Pathology Report <input type="checkbox"/> Progress Notes <input type="checkbox"/> Acctg of Disclosure	<input type="checkbox"/> All Records <input type="checkbox"/> Other _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Do you want the Hospital/Clinic to release your psychotherapy notes (if any) to the person or facility you have listed above? (Circle One) YES NO _____(initial here)					
Describe the purpose /reason for this request:					

Section B: Must be completed by the patient for all authorizations:

The patient or the patient's representative must read/acknowledge the following statements:

1. I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on ____/ ____/ _____. *(If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)*
3. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
4. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
5. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
6. I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
7. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

(Signature of Patient or Patient's representative)	(Date)
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(If patient representative, please print name below and provide proof/documentation the representative has which provides the authority to act for the patient.)