Unified Premier
Women's Care

574 Church Street, Marietta, Georgia 30060
770-427-0285 Fax: 678-564-1033
www.unifiedpremierwomenscare.com

Medical Information Release

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate the Authorization.

Date:_____

Name of Patient:_____Account #_____

DOB:_____ Patient phone number(s):_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby request and authorize Drs. Street, Robbins, Cauthen, Goh, or Epps:

CHECK ONE: ☐ To release to: ☐ To request from: ☐ To prepare for pick up

Name:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

The following information:

1. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received – OR
   ☐ Only the following records or types of health information (including any dates):
   _____

2. I specifically authorize release of the following information (check as appropriate):

   ☐ Mental health treatment information.[1] (A separate authorization is required to authorize the disclosure or use of psychotherapy notes.)
   ☐ HIV test results
   ☐ Alcohol/drug treatment information
   ☐ Other _____

PURPOSE

Purpose of requested use of disclosure:

Choose one: ☐ Patient request ☐ Transfer of Care, OR ☐ Other _____

Are you leaving the practice? _____ Should we cancel any future appointments? _____

If yes, please provide a reason: _____

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EXPIRATION

This Authorization expires:
Choose one: ☐ One year from date of signature ☐ No expiration, OR ☐ Other _____

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re- disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

Patient Name (print)_____
Signature:_____
Date:_____Time_____am/pm

If signed by someone other than the patient, state your legal relationship to the patient: _____
Witness:_____Date: _____