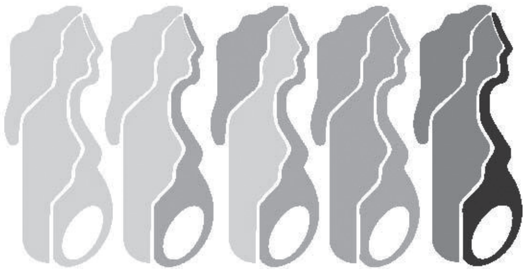
Obstetrics & Gynecology of Atlanta



Ob/Gyn
Thomas E. Sharon, M.D.
Kirsten L. Franklin, M.D.
Genevieve L. Fairbrother, M.D.
Charles D. Wootten, M.D.
Claire A. Parker, M.D.
Keisha N. Dennard-Hall, M.D.
Jill J. Henke, M.D.
Christopher E. Bassil, M.D.
Jennifer A. Loehle, M.D.
Kristen H. Lady, M.D.
Sara F. Jennings, M.D.

Nurse Midwives
Jennifer Afman, CNM
Kristy Bedell, CNM
Melissa Burke, CNM
Mitra Davis, CNM
Laura Griffaw, CNM
Hannah Grogan, CNM
Teri Nicholson, CNM
J.Nicole Robinson, CNM
Natalie Whitworth, CNM
Katherine Wunderle, CNM

Authorization to Release Medical Information

Phone 404-252-1137 Fax 866-912-2454

Patient Name (Print): ____________________
Current Address: ____________________
Home #: ____________ *Cell #:* ____________ *Date of Birth:* ____________

Who has the information you would like released?
Dr. Name: ____________ *Business Name:* ____________
Address: ____________ *Ste. #* _____ *City:* ________ *State:* _____ *Zip:* ________
Phone #: ____________ *Fax #:* ____________

To Whom should the information be sent?
Name: ____________ *Business Name:* ____________
Address: ____________ *Ste. #* _____ *City:* ________ *State:* _____ *Zip:* ________
Phone #: ____________ *Fax #:* ____________

Reason for Request:
☐ *Selected new physician in the area* ☐ *Second opinion / Consult* ☐ *Change of Insurance* ☐ *Moving out of town*
☐ *Other* ____________________

Portion of records to be released:
☐ *Entire medical record* ☐ *Other (describe in detail)* ____________________

Restrictions: *I understand that the recipient of this information may not use or disclose this information except for the express purpose identified above, unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.*

Notice: *Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnoses, treatments, assessments, recommendations for further care, names of all health care personnel, dates of hospitalization and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and /or sexually transmitted diseases, including HIV/AIDS information. By signing this form I acknowledge and understand there may be a charge for the administration and copying of my medical records.*

Exclusions (Please initial):
_____ *Drug / Alcohol* _____ *Mental Health / Psychiatric* _____ *Sexually Transmitted Disease* _____ *HIV / AIDS*

This authorization is valid for one year or until ____________________, *whichever comes first.*

Patient Signature: ____________________ ***Date:*** ____________

A Photocopy of this release is as valid as the original

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.

Northside • 1100 Johnson Ferry Road, N.E. • Suite 800 • Sandy Springs, Georgia 30342 • (404) 252-1137
East Cobb • 4800 Olde Towne Parkway • Suite 200 • Marietta, Georgia 30068 • (770) 565-2233
Johns Creek • 3890 Johns Creek Parkway • Suite 300 • Suwanee, Georgia 30024 • (678) 775-2300
Forsyth • 1800 Northside Forsyth Drive • Building 1800 • Suite 280 • Cumming, Georgia 30041 • (404) 257-5500