



AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may be redisclosed and may no longer be protected by federal privacy regulations.

Patient name: \_\_\_\_\_ Chart#: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_

Persons/Organizations authorized to release the information: Georgia Reproductive Specialists, LLC

5445 Meridian Mark Road, Suite 270

Atlanta, Georgia 30342

Persons/Organizations authorized to receive the information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specific description of information:

History/Physicals, including drug/alcohol \_\_\_\_\_ Consultations \_\_\_\_\_ Progress Notes \_\_\_\_\_
Ultrasound Reports \_\_\_\_\_ Lab Reports, including HIV test results \_\_\_\_\_ Operative Reports \_\_\_\_\_
Fertilization Reports \_\_\_\_\_ Obstetrician Release \_\_\_\_\_ Other: \_\_\_\_\_

The patient or the patient's legal representative must read and initial the following statements:

1. I understand that this authorization will expire in 90 days. Initials: \_\_\_\_\_

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have an effect on any actions taken before the organization received the revocation. Initials: \_\_\_\_\_

Send revocations to: GRS, Attn: Privacy Officer, 5445 Meridian Mark Rd., Suite 270, Atlanta, GA 30342

To be completed by the Practice:

- 1. The purpose of the use or disclosure is: \_\_\_\_\_
2. The Practice will/will not receive direct or indirect remuneration or compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: The patient or the patient's legal representative may inspect and/or copy the protected health information to be disclosed in accordance with the Practice's access policies.

The Practice does not limit its right to make a use or disclosure of your information that is required by law or permitted to avert a serious threat to the health or safety to the public. I understand that there may be a fee for copies of my medical records.

Signature of patient or patient's legal representative \_\_\_\_\_ Date \_\_\_\_\_