SAVANNAH OB/GYN, PC

Alan E. Smith, MD • Amy C. Burgett, MD • Ashley Hunsuck, MD • Elizabeth McIntosh, MD • Sarah Jarrell, MD • Lawrence Odom, MD • Glen Scarbrough, MD

Authorization for Release of Health Information

This form applies only to the release and disclosure of your health information to another medical provider. It is not intended for any other purpose. By signing this form, I authorize: Savannah OB/GYN, PC to RELEASE protected health information needed for my treatment TO:

PROVIDER NAME: ____

ADDRESS: ____

PHONE NUMBER: ________________________________ FAX NUMBER: ______________________________

Note: This authorization expires upon fulfillment of request.

I authorize copies of my medical records to be RELEASED by DR: ___________________________________

Savannah OB/GYN, P.C.
5356 Reynolds Street, Suite 410 • 5353 Reynolds Street, Suite 300
Savannah, GA 31405

I understand that this information may include any history of or references to acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health/psychiatric care, treatment for alcohol and/or drug abuse; or similar conditions. I understand that Savannah OB/GYN assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release Savannah OBGYN from all legal liability that may arise from release of my information under this authorization.

PATIENT SIGNATURE: ____ DATE: _________________________

PRINTED NAME: ____ DOB: __________________________

If the signature above is not that of the patient, I am acting for the patient because:

____

Relationship: ______________________ Signature: ____

Savannah ObGyn, P.C.