



Haven Ob/Gyn

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release, disclose, and/or provide protected health information (PHI) to/from Brad Moore MD, Obstetrics and Gynecology, P.C. and/or Haven Ob/Gyn, LLC. This authorization permits the release of my protected health information specifically as described in the space below. This authorization will expire 30 days from the date of my signature below.

- Please release all my medical records
- Please release only my prenatal records

Please send my records to:

Please release only my:

_____ Labs

_____ Radiographic Studies

_____ Progress Notes and Office Visits

_____ Other (please specify) _____

Please release a copy of my records to me

The purpose of my releasing this information is to continue my medical care with Haven Ob/Gyn. Any delay in sending this information may cause a delay in the administration of proper and necessary medical care. Thank you kindly for your assistance.

Please fax the information (unless otherwise specified) to the fax number at the top of this authorization and again here: FAX (770) 399-5726.

Signature of Patient

Signature of Witness

Name (please print)

Social Security Number

Date of Birth

Today's Date