AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:____________________Date of Birth: ______________________

I authorize the use or disclosure of the above named individual's health information as described below:

The following individual or organization is authorized to make the disclosure:

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Phone:________________________________Fax: _____________________

The type and amount of information to be used or disclosed is as follows:

_______entire record
_______laboratory results
_______problem list
_______medication list
_______x-ray and imaging reports
_______Other

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization: Centro Prenatal de Georgia / Dr. Valisia Andrews and Dr. Neale Freeman
For the purpose of:

to continue with medical care.

____ __________________________

Signature of patient Date