575 West Pike St. Suite 1
Lawrenceville, GA 30046
770-277-0230
Fax 770-277-0279

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

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

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

_____

Phone:_____ Fax: _____

3. 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 _____

4. 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.

5. This information may be disclosed to and used by the following individual or organization: Centro Prenatal de Georgia / Dr. Marc-Andre Jean-Gilles/ Dr. Esteves/.
For the purpose of: to continue with medical care.

_____ _____
Signature of patient Date