Medical Records Release and Authorization for use or disclosure of Protected Health Information

Patient Name: _____ Date of Birth:_____ Address: _____Phone Number: _____
_____

Authorization is hereby granted to _____ to Obtain/Release a complete copy of my medical information and reports beginning with the first office visit, hospitalization, or medical treatment, or any parts thereof to the person or entity listed herein:

Dr. Abby Abisogun
Shoreline Endocrinology
7505 Waters Avenue, Suite A9
Savannah, GA 31406
Phone (912) 483-9313
Fax (912) 446-0549
Email info@drabbyendo.com

Please disclose full and complete protected medical information relevant to my treatment including the following:
_____

Specific dates of treatment: _____

All information I authorize to be obtained or released from this entity will be held strictly confidential and cannot be released again without my written consent.
I am aware of and specifically give consent to the release of, or waive any privilege regarding the following information, which may or may not be contained in the records:

1. Communication made by me to a psychiatrist (O.C.G.A. Section 24.9.21)
2. Communication made by me to a licensed applied psychologist (O.C.G.A. Section 43.39.16) 3. Medical information concerning drug dependency (O.C.G.A Section 26.5.17)
4. Medical information concerning alcohol and drug dependence (O.C.G.A. Section 37.7.166) 5. Medical information concerning mental retardation (O.C.G.A. Section 37.4.125) 6. Medical information concerning alcohol and drug abuse (42 CFR Part 2)
7. Medical information concerning acquired immune deficiency syndrome.

_____ _____
Signature of Patient/Parent/Legal Guardian Date