



MAA
Women's Health

RELEASE OF PERSONAL HEALTH INFO

Full Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

I PERMIT THE LISTED PEROSN, FIRM, OR ENTITY TO DISCLOSE MY PERSONAL HEALTH INFORMATION FOR INSPECTION, COPYING AND USE TO MY TREATMENT, HOSPITALIZATION, OR CARE.

Records / Reports

Entire Record	☐	Laboratory Reports	☐
Hospital Admission Report	☐	Radiology Reports	☐
Emergency Report	☐	Pathology Reports	☐
Labor and Delivery Report	☐	Operative Reports	☐
Office Visits	☐	Other:_____	☐

Reason for Records Request

Employment	☐	Patient Discontent	☐
Relocation	☐	Second Opinion	☐
Insurance Change	☐	Other:_____	☐

To

MAA Women's Health
566 Peachtree Parkway, Suite 121
Cumming, GA, 30041
Ph: (470)-866-3200
Fax: (470)-866-3270
Email: admin@maawomenshealth.com

From

Doctor name:_____

Medical Facility Name:

Address:_____

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation ro MAA Women's Health LLC

I understand this revocation does not apply to previously released information

I understand that I do not have to sign this authorization. I recognize that once information is disclosed under this authorization, the recipient may further disseminate the information, and it may no longer be safeguarded by Federal privacy regulations.

Patient Signature:_____

Date:_____