Please Note: So that we may maintain the most up to date and accurate information on our patients, in addition to the face sheet presented to you at every visit, we will request that you review and update this form at least once a year.

DATE:___________________

PATIENT INFORMATION

Patient Name: First_________________________ MI_______ Last_________________________ SS# ___________________

DOB:_______________ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Parent / Legal Guardian Name if patient is a minor Name_________________________ DOB_______________

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Declined
Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined

Preferred Language: English________ Spanish________ Vietnamese ________ Other_________________________

Do you have any communication difficulties/ special needs? Hearing Loss Interpreter Required Reading Difficulty Sight Impaired Other? Yes No

If yes, please list: ____

Address: _________________________ Apt # ________ City_______________ St________ Zip ___________

Phone: Home_________________________ Cell_________________________ Work_________________________

E-Mail____

Best Contact Method: ☐ Home ☐ Cell ☐ Work ☐ E-Mail ☐ Mail By checking one of the boxes for Best Contact Method, I agree to receiving correspondence from St. Theresa's Obgyn

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired Employer/School:_________________________

FINANCIALLY RESPONSIBLE PARTY

☐ **same as Patient Information** *(If different, please complete section below)*

Name: First_________________________ MI_______ Last_________________________

Relationship: Spouse Parent Guardian Other (Please Specify): _________________________

Address: _________________________ Apt #__________ City_______________ St________ Zip ___________

Phone: Home_________________________ Cell_________________________ Work_________________________

Email Address ____

Employer: ____

EMERGENCY NOTIFICATION

Name: ____ Relationship to Patient: _________________________

Phone: Home_________________________ Cell_________________________ Work_________________________

Name: ____ Relationship to Patient: _________________________

Phone: Home_________________________ Cell_________________________ Work_________________________

REFERRAL SOURCE

☐ Friend/Family Member ☐ Insurance Company ☐ Walk-In ☐ Phone Book ☐ Direct Mail ☐ Radio Ad ☐ Newspaper_______________
☐ Magazine _______________ ☐ Web Search ☐ Practice Website ☐ Event ☐ another Physician/Provider _______________
☐ Other _______________
☐ Other Advertisement _______________ ☐ Hospital / ED _______________

Continue to the Back of this Page

FOR OFFICE USE ONLY:

*Patient Name*____________________

*MRN*____________________

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

☐ **Do Not Release Information**

I authorize St. Theresa's Obgyn and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to St. Theresa's Obgyn of changes or update. I authorize St. Theresa's Obgyn to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name ____________________ Relationship________________ Phone________________

You may release the following information to the person named above: ☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave Message

Name ____________________ Relationship________________ Phone ________________

You may release the following information to the person named above: ☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave Message

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet. **Initials** ____________

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

INSURANCE INFORMATION

Medicare ID# ____________________

Do You Have Insurance Primary to Medicare? Yes No If Yes, Please List: ____________________

Medicare Supplement ____________________ ID# ________________

Medicare Advantage Plan ____________________ ID#________________

Medicaid ID# ____________________

Or

Commercial Insurance

Primary Insurance________________ ID ________________ Gp: ____________

Policy Holder Name:____________________ Relationship (Circle One) Self Spouse Parent Other ____________

SS#________________ Policy Holder's DOB________________ Employer________________

Secondary Insurance________________ ID: ________________ Gp ____________

Policy Holder Name:____________________ Relationship (Circle One) Self Spouse Parent Other ____________

SS#________________ Policy Holder's DOB________________ Employer________________

MEDICATION REFILL

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request. **Initials** ____________

Pharmacy Name____________________ Address or Cross Street____________________

FOR OFFICE USE ONLY: Patient Name____________________
MRN____________________

PRIVACY PRACTICES

Our office, physicians and staff, are committed to securing the privacy of your health information. Signature____

We are making available to you a copy of our Notice of Privacy Practices. Date ____________________

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.

I understand that in the event I do not cancel my appointment within twenty-four hours of the scheduled appointment that the clinic may charge a cancellation fee. I authorize direct payment of my insurance benefits to St. Theresa's Obgyn for services rendered to myself or dependents.

Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.

Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information. Out of Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.

St. Theresa's Obgyn or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.

CONSENT TO CREDIT BUREAU INQUIRIES

I hereby consent to credit bureau inquires and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process I understand that these collection attempts could be performed by St. Theresa's Obgyn or its affiliates/agents including, without limitation, any account management companies, independent contractors or collections agents.

Y ________ N _______

Lab / X-Ray / Diagnostic Services:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I consent to treatment necessary to the care which has been discussed and directed by the provider.

I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

I further authorize and request that insurance payments be directed to St. Theresa's Obgyn

Authorization to Treat a Minor (Ages 0-18th Birthday)

Not Applicable (patient is an adult)

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers St. Theresa's Obgyn to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to St. Theresa's Obgyn of changes or update. I authorize St. Theresa's Obgyn to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name ______________________ Relationship______________ Phone________________

Name ______________________ Relationship______________ Phone________________

Name ______________________ Relationship______________ Phone________________

I have read, fully understand and agree to the above **medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment** and **release of medical information & insurance authorization.** I also certify that all of the information, provided is complete and accurate.

Patient Name ____________________Signature ______________________Date______________

Health Information Exchange Authorization

____________________________________participates in health information exchanges as described in the St. Theresa's Obgyn Resources (physician/clinic/facility name)
Health Information Exchange Patient's Frequently Asked Questions document which may be revised at any time.

A Health Information Exchange (HIE) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. A Health Information Exchange is an electronic health information system that stores your patient health information from multiple healthcare providers participating in the HIEs. It allows your other health care providers to view your past health information for continued care and other uses included in the provider's Notice of Privacy Practices. Your information will be stored within the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.

I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that Information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may be included.

I authorize the above provider to disclose my medical information described above to the HIEs in which St. Theresa's Obgyn participates. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by other providers and such information may no longer be protected.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the above provider for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

Hospital Visit for Obstetric patients only: I also give this authorization for any child (ren) born to me during this visit.

I authorize release of my medical information to the Health Information Exchanges in which St. Theresa's Obgyn participates:

______ Yes ______ No

Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Health Information Exchange Authorization form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

Print Patient's Name	Date of Birth	Address
Signature of patient or authorized representative	Relationship to patient or self	Date
Witness	Title	Date

NAME: ____________ DATE: ____________ CHART: ____________

GENERAL INFORMATION

1. a. **Date of Birth:** ____ Month ____ Day ____ Year
   b. **Gender:** Male / Female
   c. **Weight:** ______ lbs.
   d. **Height:** ____ ft. ____ inches
   f. **Employed?** Yes No

GENERAL MEDICAL INFORMATION

2. Please rate your health. Excellent Very Good Good Fair Poor
3. Has there been a change in your general health in the past year? Yes No
4. Your Physician: ____________ City ____________ Phone No.: ____________
5. Date of last physical examination: Month ______ Year ______ Currently under treatment by a physician? Yes No
   Please explain ____________
6. Do you engage in regular exercise? Yes No Type ____________
7. **Do you need to take antibiotics prior to receiving dental or surgical care?** **Yes** **No** **Don't know**

MAJOR HOSPITALIZATIONS, SURGERIES, AND BLOOD TRANSFUSION → MARK HERE IF NONE — VERIFIED BY EXAMINER

8.

DATE (Month/Year)	REASON

ALLERGIC OR UNUSUAL REACTION TO ANY OF THE FOLLOWING? → MARK HERE IF NONE — VERIFIED BY EXAMINER

9. Penicillins, Sulfa drugs, Aspirin, Local anesthesia, Opiates/codeine, Iodine, Latex

Other drugs:
List: 1. ______
2. ______
3. ______

Other substances (food, metals, etc.)
List: 1. ______
2. ______
3. ______

Type of Reaction ____________

WOMEN ONLY → NOT APPLICABLE

10. **Are you** **PREGNANT?** ______ weeks? Trying to become pregnant? Not sure if you are pregnant?
    Using birth control pills ______ (Name of Prescription) Going through menopause? Post-menopausal?

PRESCRIPTION/ NON PRESCRIPTION MEDICATIONS → MARK HERE IF NONE — VERIFIED BY EXAMINER
(Use continuation page if necessary)

11. List all medications and herbal supplements/remedies that you are currently taking.

	Name:	For what Condition?	Dose/Frequency of use:
A)			
B)			
C)			
D)			
E)			
F)			

GENERAL MEDICAL INFORMATION - PRESENT SYMPTOMS

12. Mark symptom(s) that you NOW experience or HAVE RECENTLY experienced. → ○ MARK HERE IF NONE
○ VERIFIED BY EXAMINER

GENERAL
- Weight loss________ Lbs. Over what time period? __________
- Weight gain________ Lbs. Over what time period? __________
- Loss of appetite ________________
- Always hungry ________________
- Always thirsty ________________
- Frequent urination________________
- Fatigue ________________
- Faint easily ________________
- Night sweats________________
- Bleed easily ________________
- Bruise easily________________

CARDIOVASCULAR
- Shortness of breath with exertion________________
- Racing or irregular heart beat________________
- Swollen ankles ________________
- Cold ankles/feet ________________
- Chest pain/angina________________

RESPIRATORY
- Coughing spell________________
- Wheezing________________
- Use 2 or more pillows to sleep________________

MUSCULOSKELETAL
- Joint pain ________________
- Swollen joints ________________
- Muscle cramping________________

SKIN CHANGES
- Skin problems________________
- Nail changes________________

NEUROLOGICAL
- Numbness/tingling________________
- Paralysis/weakness________________
- Memory changes________________
- Smell/taste changes________________
- Difficulty chewing________________
- Swallowing changes________________
- Speech changes________________
- Dizzy spells or fainting________________

GASTROINTESTINAL
- Indigestion ________________
- Reflux/heartburn________________
- Nausea/vomiting________________
- Bowel problems________________

HEAD & NECK
- Neck pain________________
- Neck lump/swelling________________
- Headache________________
- Facial pain ________________
- Jaw pain________________

SALIVARY
- Need liquid to swallow dry foods________________
- Mouth feels dry when eating a meal________________
- Difficulties swallowing any foods________________
- Sense of too little saliva________________
- Sense of too much saliva________________

EYES
- Vision changes________________
- Dry eyes________________

EARS
- Hearing loss________________
- Ringing ears________________
- Earaches ________________
- Pressure/stuffiness in ears________________

NOSE/THROAT
- Congested/runny nose________________
- Nose bleeds ________________
- Nasal obstruction ________________
- Sore throat ________________
- Hoarseness/voice changes ________________
- Mouth breathing/ snoring ________________

PAIN
- Back pain________________
- Other pains ________________

BEHAVIORAL
- Stress________________
- Sleep difficulties________________
- Feel depressed ________________
- Feel agitated/anxious________________
- Other ________________

FAMILY MEDICAL HISTORY

○ MARK HERE IF NO ONE IN YOUR FAMILY HAS *EVER* HAD ANY OF THE PROBLEMS LISTED BELOW

○ VERIFIED BY EXAMINER:

13. Darken the circle beside medical problems that have been present in your parents, brothers/sisters, or close relatives.

- Genetic (inherited) disease ________________
- Liver/kidney disease________________
- Immune system disease ________________
- Diabetes________________
- Bleeding disorders ________________
- Tuberculosis________________
- Neurologic disease________________
- Other (include cancer)________________

MEDICAL HISTORY - PAST AND PRESENT ILLNESS

14. Darken the circle for illnesses that you CURRENTLY HAVE or HAVE HAD IN THE PAST

MARK HERE IF NONE VERIFIED BY EXAMINER

Cancer & Neoplastic Disease
- Cancer____________
- Leukemia/Lymphoma ____________

Genetic (inherited) Disease
- Type____________

Immune System Disorder
- Rheumatoid arthritis____________
- Lupus erythematosus____________
- Sjogren's Syndrome____________
- Other____________

Hormonal or Metabolic Disorders
- Diabetes____________
- Thyroid problems ____________
- Adrenal insufficiency____________
- Other____________

Heart/Blood Disorders
- High blood pressure____________
- Artherosclerosis____________
- Heart attack ____________
- Coronary artery disease____________
- Heart murmur____________
- Heart valve problems____________
- Bleeding disorder____________
- Anemia____________
- Other ____________

Neurological Disorders
- Epilepsy/Seizures____________
- Neuralgia ____________
- Stroke____________
- Other____________

Chronic Pain
- Back ____________
- Abdominal____________
- Headache/Migraine ____________
- Other____________

Head and Neck Conditions
- Injury to face, jaws, neck ____________
- Concussion____________
- Radiation treatment ____________
- Temporomandibular joint disease ____________
- Salivary gland problems____________
- Sinusitis ____________
- Glaucoma____________
- Other ____________

Gastrointestinal Disorders
- Acid-reflux /Heartburn____________
- Ulcer/Gastritis____________
- Irritable bowel syndrome/Colitis ____________
- Other____________

Lung/Airway Disorders
- Emphysema____________
- Pneumonia____________
- Bronchitis____________
- Asthma____________
- Tuberculosis____________
- Sleep Apnea____________
- Other____________

Skin Disorders
- Skin cancer____________
- Skin infections ____________
- Other____________

Other Major Organ Disease
- Kidney disease____________
- Liver disease____________
- Organ transplant____________
- Spleen surgery____________
- Other ____________

Infectious Diseases
- Rheumatic fever____________
- Strep Throat____________
- Mononucleosis____________
- Hepatitis____________
- Sexually-transmitted diseases____________
- HIV/AIDS ____________
- Other____________

Behavioral Conditions
- Psychiatric illness____________
- Anxiety/Panic attacks____________
- Depression____________
- Suicide attempt or thoughts ____________
- Other____________

Habits/Addiction
- Drug abuse____________
- Alcohol abuse____________

Other Conditions
- Disabled ____________
- Prosthetic valve ____________
- Prosthetic joint ____________

Additional Notes:

15. CONSUMPTION OF BEVERAGES AND OTHER SUBSTANCES → **MARK HERE IF NONE VERIFIED BY EXAMINER**

a. Number of caffeinated beverages you drink in a day:

0 1-2 3-5 5+

b. Number of alcoholic beverages you drink in a week:

0 1-2 3-5 6-10 10+

d. Number of carbonated beverages a day:

0 1-2 3-5 5+

c. Currently using any street or recreational drugs?
No Yes (Type?)____________________

e. Have you ever used tobacco? No Yes

If yes, what type:
Cigarette Pipe/Cigar Smokeless

f. Do you currently use tobacco? No Yes

If yes, average number of uses per day: ________

For how many years? _____

16. **DENTAL HISTORY : Darken the circle beside items that describe your past dental problems and dental care.**

Regular dental care
Occasional dental care
Wisdom tooth extractions
Orthodontics
Gum disease (pyorrhea, gingivitis or periodontal disease)
Treatment for jaw trauma/fracture (Type?)____________________
Had an adverse reaction to dental treatment (Please describe)____________________
Dental fears or anxiety____________________

17. Rate your ORAL HEALTH in general. Excellent Very Good Good Fair Poor

18. How good a job do you feel you are doing in taking care of your oral health?
Excellent Very Good Good Fair Poor

19. Date of last regular dental visit: ____ _____ Name and address of dentist: ____________________
Month Year

FAMILY DENTAL HISTORY

20. Darken the circle beside oral problems that have been present in your parents, brothers/sisters, or close relatives.
Caries Gum disease (pyorrhea, gingivitis or periodontal disease) Dry Mouth TMJ disorder

Additional Notes or Comments:

Patient's Signature____________________**Date**__________

Reviewed by (Student)____________________
Date__________

Reviewed by (Faculty) ____________________
Date__________

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: ____________________

Date of Birth: ____________ SSN: ____________

I. My Authorization

I authorize the following using or disclosing party:

____

To use or disclose the following health information: (check one)

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

____

☐ - My health information covering the period from ________ (date) to ________ (date)

☐ - Other: ____________________

The above party may disclose this health information to the following recipient:

Name (or title) and organization ____________________

Address ____________________

City ____________ State ____________ Zip ____________

Phone ____________ Fax ____________ Email ____________

The purpose of this authorization is: (check all that apply)

☐ - At my request

☐ - Other: ____________________

☐ - To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends: (check one)

☐ - On (date)____________________

☐ - When the following event occurs: ____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ____________________________________

Date: ____________________

<u>If the patient is a minor or unable to sign, please complete the following</u>:

☐ - Patient is a minor: _______________ years of age

☐ - Patient is unable to sign because: ____

Signature of Authorized Representative: ____

Date: ___________________

Print Name of Authorized Representative: ______________________________

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: ____________________

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.** Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ______________________________

Date: ____________________ Time: ____________________

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment.** Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ______________________________

Date: ____________________ Time: ____________________

Dr. Gertrude Anyakwo, MD, FACOG
Noelle Newsome, FNP-C

ph 470-545-5551 *fx* 470-545-9031
2311 Henry Clower Blvd SW Ste E. Snellville GA 30078

Informed Authorization and Consent for the release of Medical Records

Patient Infomation: Name: ______________________ DOB: ______________

Address: ______________________________

Contact Number: ______________________

( ) **RELEASE TO:**

____
____
____

( ) **OBTAIN FROM:**

____
____
____

for the purpose of: ______________________________

Please indicate what specifically is to be released:

( ) Entire Medical Record ( ) Mammography ( ) Laboratory Tests

( ) Discharge Summary ( ) Operative Reports ( ) Pathology

( ) Other: ______________________________

I understand that these medical records may or may not contain information pertaining to alcohol or drug abuse counseling or testing, and/or HIV/ARC testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. This authorization/consent will remain in effect for a period of one (1) year from the date stated below, unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian or legally authorized agent), to the Medical Records Department. These medical records are being disclosed under the provisions of the applicable Georgia State and Federal Law.

______________________ ______________________

Patient Signature *Date Signed*