

GARRY E. SIEGEL, M.D., P.C.

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**AUTHORIZATION FOR RELEASE OF INFORMATION  
REQUEST FOR MEDICAL RECORDS**

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**Section A: Must be completed for all authorizations**

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer be protected by federal privacy regulations.

**Patient name:** \_\_\_\_\_ **Account Number:** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**To: North Pointe OB/GYN Associates, L.L.C.**

Please send the entire original medical record to:

Garry E. Siegel, M.D., P.C.  
3400-C Old Milton Parkway, Suite 365  
Alpharetta, GA 30005  
770.664.7013 voice  
770.475.1712 fax

**Section B: Must be completed only if a health plan or a health care provider has requested the authorization**

1. This authorization permits the use and disclosure of healthcare information for marketing purposes.

\_\_\_\_\_ **Yes**                      \_\_\_\_\_ **No**

2. If yes, on question above, will the health plan or health care provider listed requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

\_\_\_\_\_ **Will**                      \_\_\_\_\_ **Will Not**

3. The information will be used /disclosed for the following purpose(s) [All purposes must be listed and described:

**Purpose 1:** \_\_\_\_\_

**Purpose 2:** \_\_\_\_\_

4. The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

**Initials:** \_\_\_\_\_

b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

**Initials:** \_\_\_\_\_

**Section C: Must be completed for all authorizations**

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on \_\_\_\_\_ (list date or event)

**Initials:** \_\_\_\_\_

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

**Initials:** \_\_\_\_\_

3. If this authorization is obtained as a condition to obtaining insurance coverage, other law provides the insurer the right to contest a claim under the policy or the policy itself

\_\_\_\_\_  
**Signature of patient or patient's representative**  
*(Form MUST be completed before signing)*

\_\_\_\_\_  
Date

**Printed name of patient's representative:** \_\_\_\_\_

**Relationship to the patient/or authority to Act for the patient:**

\_\_\_\_\_  
**If the authorization has been given by the patient's personal representative, North Pointe OB/GYN Associates, L.L.C., has verified the identity of (write in representative's name)**

\_\_\_\_\_ **by the method listed below:**

\_\_\_\_\_  
(Describe means of verification, e.g., driver's license) and that in his/her capacity of the (description of authority to act, e.g., husband, guardian, etc.), he/she is authorized to act on behalf of the patient.

**\*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\***

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

**Instructions: Please complete as best that you can and kindly:**

1. Mailing it to the Alpharetta main office.  
Garry E. Siegel, M.D., P.C.  
3400-C Old Milton Parkway, Suite 365  
Alpharetta, GA 30005
2. Faxing it to 770.475.1712.
3. Emailing it to [release@drsiegelobgyn.com](mailto:release@drsiegelobgyn.com).