SEEBABY

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone:_____e-mail_____

Address: _____

City: _____ State: _____ Zip: _____

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

1. Means to Disclose Healthcare Information

I do wish to have the availability to have any portion of my medical record submitted to me by all and/or the following below:

- ___ US Postal Mail Service
- ___ Personal Email **(Listed on account only)**
- ___ Spouse of Patient _____
- ___ All of the above

Note: Faxed copies of records are prohibited as we are unable to guarantee full confidentiality of the medical record.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

__**X**__ Complete health records
_____ Lab results/X-ray reports
_____ Physical exam
_____ Consultation reports
_____ Immunization record
_____ Other (please specify: _____

- 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.

3. *This information may be disclosed to and used by the following individual or organization.*

Name: See Baby, LLC

Address: 550 Peachtree Street, Suite 1165 Atlanta, GA 30308 Fax (404)223-9307

For the purpose of: _____

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.

5. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed.. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact See Baby's office manager at 404-223-9306.

_____ _____

Signature of patient or legal representative

Signature of witness

Date: _____

Date: _____