



Pinnacle Women's Health Center

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Obstetrics and Gynecology
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

1. I, _____, hereby authorize the use or disclosure of the above named individual's health information for the purpose of medical treatment.
2. I understand these records may contain information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug abuse, alcoholism, sickle cell anemia and behavior or mental health services.
3. This information may be disclosed to and used by the following individual or organization:

Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

4. For the following purpose: (check all that apply)
 Legal Issues Insurance claim Personal Use
 Continuing Care Other: _____
5. I understand that this authorization, except for action already taken, may be revoked by me at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Pinnacle Women's Health Center. Unless otherwise revoked, this authorization will expire 90 days from today's date and must be post date of service being requested.
6. I understand that Pinnacle Women's Health Center will not condition treatment, payment, enrollment, or eligibility for benefits concerning my health care on whether I sign or refuse to sign this authorization.
7. I understand that authorizing the disclosure of this health information is voluntary and that disclosure of such information carries with the potential for un-authorization or re-disclosure.

Signature of Patient or Legal Representative

Date

Print Name

Relationship to Patient

Signature of Witness