**CURTIS V. COOPER PRIMARY HEALTH CARE, INC.**

CVC Women's Center
5354 Reynolds Street
Savannah, Georgia 31405
Suite 421
Phone: (912) 629-8110
Fax: (912) 629-8103
Email: jtoraya@cvcphc.com

# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Patient Name:**_____**Date of Birth:** _____
**SSN:**_____**Account Number** _____
**CVCPH Provider** Jules Toraya, M.D.

**By signing below, you hereby authorize us to RELEASE OR OBTAIN information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below.**

**Information to be RELEASED and purpose of the use and disclosure:**

**__X__Medical___Psychiatric___Psychological____Drug / Alcohol _____**
**_____Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS)**
**_____Other_____**

**At this time, our center does not accept CD records.**

**INFORMATION THAT MAY NOT BE RELEASED:**

**_____Medical_____Psychiatric_____Psychological_____Drug/Alcohol**
**____Human Immunodeficiency Virus (HIV)/ Acquired immune Deficiency Syndrome (AIDS)**
**_____Other _____**

**The information will be <u>RELEASED TO OR OBTAINED FROM</u>:**

South Coast OB/GYN
**Name of Entity**

5353 Reynolds St. #300
**Street**

| Savannah | GA | 31405 |
|---|---|---|
| **City** | **State** | **Zip Code** |

**The information will be used or disclosed for the following purpose:**

_____

_____

_____

_____At the request of the individual

This authorization will expire on: _____
Date or Defined Event

Curtis V. Cooper Primary Health Care, Inc., its directors, officers, and employees are hereby released from any legal responsibility or liability for disclosure of the above information

I do not have to sign this authorization in order to receive treatment from Curtis V. Cooper Primary Care, Inc. In fact, I have the right to refuse to sign this authorization.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this Authorization in writing except to the extent that Curtis V. Cooper Primary Health Care, Inc. has acted on reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

106 East Broad Street
Savannah, Georgia
31402

A photocopy or fax of this authorization is as valid as the original.

Signed by:_____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Print Name of Patient or Legal Guardian — Date

Witnessed by: _____
Signature of CVCPHC Employee