



**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:

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 **RELEASED TO OR OBTAINED FROM:**

Name of Entity: South Coast Health

Address: 330 Benfield Dr.  
Savannah, GA 31406

Attention: Sue Hunnings

Fax: 912-303-3506

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Serving the Savannah area by providing preventive and primary health care services

\_\_\_\_\_ 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