

**Premier Women's Healthcare**

Dominique J. Smith, M.D.  
5900 Hillandale Dr., Annex A  
Lithonia, Ga. 30058  
(678) 418-6990 Fax (678) 418-6986

Patient Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
\_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_

**AUTHORIZATION TO RELEASE/OBTAIN  
PROTECTED HEALTH INFORMATION  
I AUTHORIZE:**

**TO RELEASE TO:**

\_\_\_\_\_  
Name of sending organization/ entity  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip Code

Premier Womens Healthcare, LLC  
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**Information to be released: (Please specify below date of service to be disclosed)**

- All medical Information
- OB/GYN
- Progress Note
- Laboratory Reports
- Physical Examination
- Other (specify) \_\_\_\_\_
- HIV/AIDS

**Reason for Disclosure:**

- Continuity of Care
- Personal Use
- Insurance Claim
- Social Security
- Attorney Inquiry
- Worker's Comp
- Consultation
- Other (Specify)

- I understand that I, or the person authorized to act on my behalf, am entitled to receive a copy of this authorization..
- The requestor may be provided with a copy of this authorization.
- I understand that I may inspect my records and that a reasonable fee may be charged for the duplication of records.  
An estimate of charges will be provided upon request before duplication.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I also understand that this authorization shall expire in 90 days from the request date, unless I specify another date. Specify date here: \_\_\_\_\_. If I decide to revoke this authorization, I will submit my written request to the Supervisor of Medical Records at the above listed address.
- I am authorizing any physician, nurse, hospital or other provider having treated or attended me having possession of any record and/ or information with respect thereto, to provide such records to the requesting party identified above.

**By signing below you are hereby authorizing Premier Womens Healthcare, LLC to release/obtain the requested information identified above.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature/Parent or Legal Guardian/ Witness

