Authorization for Disclosure of Health Information

A coversheet is required when faxing this form.

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell/Work Phone: _____ - _____ - _____

I authorize the use or disclosure of the above named individual's health information as described below. I understand that the information in the individual's 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. Therefore,

Family Medicine Specialists, P.C., located at 100 Genevieve Court, Ste A, Fayetteville, GA 30215, phone: 770-486-1818, is authorized to:

_____ **Obtain** information from the named individual or organization listed below. **Please fax records to 770-486-7303.**

_____ **Disclose** information to the named individual or organization listed below.

Individual or Organization Name:_____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____

The type and amount of information to be obtained or disclosed is as follows: dates included where appropriate.

_____ Complete Health Record _____ Consultation Reports _____ Imaging reports (Radiology)

_____ Immunization record _____ Lab results _____ Physical Exam

_____ Other (please specify)_____

Purpose of the disclosure: ___ Continuing Care ___ Patient Requesting ___ Other (please specify) _____

How records are to be disclosed: ___ Fax ___ Mail to Above Address ___ Patient to Pick Up

___ May be Picked Up by: _____
Name of Person Picking up Records Relationship to Patient

I understand that I have a right to revoke this authorization 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:_____

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, as provided in CFR 164.524. 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: **Julie Rossetti/Privacy Officer for Family Medicine Specialists. 770-486-1818**

_____ _____/_____/_____

Signature of Patient **Date** 02/02/2012