North Georgia Endocrinology

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name, if applicable: _____

Street Address: _____ City/State/Zip: _____

Home/Cell Number: _____ Work Phone: _____

1. **RELEASE TO/FROM:**
   I authorize representatives from the following facility / facilities to disclose the above-named individual's health information as directed below

   Practice/Facility Name: _____

   Practice/Facility Phone: _____

   Practice/Facility Fax: _____

2. **FAX REQUESTED INFORMATION TO/FROM:**

   North Georgia Endocrinology

   Attn: Medical Records (MUST INCLUDE Patient's Full Name and DOB)

   Fax: 678-224-8879 Phone: 678-224-8686

3. **PURPOSE OF DISCLOSURE:**
   - ☐ Continuity of Care
   - ☐ Insurance Disability
   - ☐ Other:

4. **EXPIRATION OF AUTHORIZATION:**
   Unless I request in writing otherwise, this authorization will expire on _____. If I do not specify an expiration date or (insert date or event) event, this authorization will expire ninety (90) days from the date on which it was signed.

5. **DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**

   ☐ Complete medical record / health information (please specify dates of service):

   _____

   ☐ Partial medical record (please specify records below):

   _____

6. **RIGHT TO REVOKE AUTHORIZATION:** I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to the Medical Records Department of North Georgia Endocrinology or facilities checked above. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. **FEES:**
   I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee schedule may be viewed at dch.georgia.gov/medical-records-retrieval-rates.

8. **REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE:**
   I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment.

9. **RE-DISCLOSURE:**
   I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

10. **RELEASE AND WAIVER:**
    If the health information that I have requested North Georgia Endocrinology PC to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above.
    I also release North Georgia Endocrinology and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

Printed Patient Name: _____ DOB: _____

Signature of Patient (or Patient's Legal Representative) _____

Description of Authority to Act for Patient _____ Date: _____