

Atlanta Diabetes Associates
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77 Collier Rd, Suite 2080
Atlanta, GA 30309

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize _____ to use or disclose
the name of the hospital, or physician name if requesting release from a physician's office
medical records as described below.

Purpose of Use or Disclosure: At the request of the individual Other _____

Patient's Full Name _____ SS# _____

Maiden/Other Name _____ Telephone Number (Home) _____

Date of Birth _____ Telephone Number (Work) _____ Telephone Number (Cell) _____

Current Address _____

I further request and authorize use or disclosure of the medical records checked below to (please provide name and address):

This authorization applies to the information checked below for the following date or dates of service: _____

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

Entire Medical Record

Financial Record

Office Notes

Laboratory Test Results

Medication Record

Treatment Plan

EKG Report

Other – Specify _____

Notes – Specify _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. You may pick up a revocation form from the Medical Records Department and return it there after you have completed and signed it. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. Atlanta Diabetes Associates shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

I further understand that this Authorization is valid from today's date and will not expire unless a written request is provided.

Patient's or Legal Representative Signature

Please Print Name

Today's Date

As a legal Representative, my relationship to the patient is _____. Any document outlining such authority should be attached. The patient is unable to sign because _____.

There may be fees for provision of any or all requested information.