The Medical Center of Elberton, LLP & Elbert Industrial Medicine, LLC

Authorization for Disclosure of Protected Health Information

Revised 04/2002

By signing this authorization, I authorize _____, an employee of The Medical Center of Elberton, LLP and/or Elbert Industrial Medicine, LLC to use and/or disclose certain protected health information (PHI) to or for the party or parties listed below.

Patient Name (please print): _____ *Birthday:* _____ *SSN:* _____

What PHI may be used or disclosed:

This authorization permits The Medical Center of Elberton, LLP and/or Elbert Industrial Medicine, LLP to use or disclose the following PHI:

Please check which information is being disclosed and include descriptions where necessary.

_____ Name _____ SSN _____ Address _____ Date of Birth _____ Telephone Numbers _____ Account Number/Chart Number

_____ Date(s) of service _____

_____ Diagnosis _____ Codes _____ _____ _____ _____

_____ Medical info summary disclosure _____

Purpose of PHI Disclosure _____

Requesting Records/PHI From

Name: _____

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

Phone: _____ *Fax:* _____

Person/Entity and Address for Records/PHI To Be Sent

Person/Entity Name _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

I understand that when my PHI is disclosed pursuant to this authorization, it may be subject to re-disclosure 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 (i) to the extent that The Medical Center of Elberton, LLP and/or Elbert Industrial Medicine, LLC has acted in reliance upon this authorization; or (ii) to the extent that the authorization was obtained as a condition of obtaining insurance coverage, there is no other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Privacy Official at 109 College Avenue, Elberton, GA 30635, by sending a written request stating that I wish to revoke this authorization to the attention of Chief Privacy Official. I understand that The Medical Center of Elberton, LLP and/or Elbert Industrial Medicine, LLC may not condition treatment, payment, and any necessary healthcare operations on whether I sign this authorization.

Signed by: _____ Print Name: _____

(Signature of patient or personal representative)

If not signed by patient, please state authority to act on behalf of the Individual: _____

Unless otherwise noted, this authorization will expire in 180 days _____

For Office Use Only:

Signature of person making disclosure: _____ Date: _____

_____ Mailed _____ Faxed _____ Picked Up If authorization was not signed, state why: Initials