Authorization for Disclosure or Use of Protected Health Information
West Georgia Internal Medicine, P.C.

Please complete this form in its entirety. Items not checked or blanks unfilled will be considered as non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature or if it has expired as described below.

I hereby authorize (name of provider and/or entity authorized to disclose your information):

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To disclose the following information from the health records of:

Name: ____

Date of Birth: ________________________ Social Security Number: ________________________

This information is to be disclosed to: **West Georgia Internal Medicine, P.C.**
706 Dixie Street, Suite 300
Carrollton, Georgia 30117
Phone: 770.834.6208 Fax: 770.830.7620

www.internalmd.com

For the **PURPOSE** of (choose **one**): _____ Continued Medical Care ______ Personal ______ Insurance

The following may be released (please check **all** that apply):
Medical data related to:

( ) Specific condition(s): ____
( ) Specific dates of service: ____
( ) Specific test(s): ____

I understand that this may include information related to: Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV), Behavioral Health Services/Psychiatric Care, treatment for alcohol and/or drug abuse, and Sexually Transmitted Diseases.

Affirmation of Release:
By signing below, I give my permission to the above named entity to release **only** the information I have selected on this form to West Georgia Internal Medicine, P.C. I understand that this release is valid for up to one year from the date of signature, and I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, or if applicable, during a contestability period. Any revocation or refusal to sign this authorization will not affect treatment or payment. I understand that a revocation must be in writing and sent to the Privacy Office, c/o West Georgia Internal Medicine, P.C., 101 Doctors Drive, Carrollton, Georgia 30117. The revocation must include: patient's name, mailing address, social security number, date of birth, effective date of this authorization, the recipients of the protected health information according to this authorization, patient's desire to revoke this authorization, patient's signature, as well as the date of the letter of revocation. As a patient, I also have the right to access my records. Copies of the records may be obtained with reasonable notice and payment for coping cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or healthcare clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed by the recipient and no longer protected by the regulations. I also understand that I have a right to receive a copy of this authorization if I request one.

____ ________________________

Signature of Patient/Guardian/Legal Representative Date Signed