

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO THIRD PARTIES



PATIENT'S NAME	BIRTH DATE	ADDRESS
A. FOR ATLANTA NEUROLOGY TO RELEASE YOUR RECORDS: (CHOOSE A OR B)		
<input type="checkbox"/> I HEREBY AUTHORIZE ATLANTA NEUROLOGY TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PERSON TO: (Name(s) of person(s)/ organization(s) or class(es) of persons or organizations to which disclosure is to be made)		
_____	_____	_____
<i>Full Name of Physician/ Person</i>	<i>Address / Location</i>	<i>Telephone and/or Fax #</i>
B. FOR YOUR RECORDS TO BE RELEASED TO ATLANTA NEUROLOGY: (CHOOSE A OR B)		
<input type="checkbox"/> I HEREBY AUTHORIZE:		
_____	_____	_____
<i>Name</i>	<i>Address</i>	<i>Telephone #</i> <i>Fax #</i>
TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PERSON TO ATLANTA NEUROLOGY.		
For treatment date(s): _____		
For the following purposes(s) _____		
<i>If the request is initiated by the individual (or his/her representative), insert "at the request of individual;" otherwise, describe purpose of the use or disclosure. If the purpose relates to marketing, indicate whether Atlanta Neurology will receive remuneration.</i>		
CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED		
Unless the appropriate box is checked, Atlanta Neurology will <i>not</i> disclose records contained in its medical records prepared by health care providers not affiliated with Atlanta Neurology unless the records were prepared on behalf of Atlanta Neurology).		
<input type="checkbox"/> Demographic Information <input type="checkbox"/> Payment Records <input type="checkbox"/> Lab Test Results <input type="checkbox"/> Admission History & Physical <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Operative/Procedure Reports <input type="checkbox"/> Imaging/Radiology Reports	<input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> Physician Orders <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Billing Records <input type="checkbox"/> Other _____	<input type="checkbox"/> Entire Record (will not include Billing Records or records not prepared by or on behalf of Atlanta Neurology unless those items also are selected). <input type="checkbox"/> Records not prepared by or on behalf of Atlanta Neurology. Atlanta Neurology cannot be responsible for the completeness or accuracy of such records.
This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.		
I understand that the records to be used or disclosed pursuant to this authorization may contain _____ (initial) records relating to participation in any federally assisted drug and alcohol abuse program; _____ (initial) information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); _____ (initial) information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.		
I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to \$25 per request, a copying charge of \$0.97 per page for the first 20 pages, \$0.83 per page for pages 21-100 and \$0.66 for each page in excess of 100, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it or except as otherwise stated in Atlanta Neurology's Notice of Privacy Practices, by mailing or hand-delivering written notification to the following person: Privacy Officer, Atlanta Neurology, 993-F Johnson Ferry Road, NE, Suite 120, Atlanta, GA 30342.		
_____	_____	
<i>Date</i>	<i>Signature of Individual/ Individual's Representative</i>	
_____	_____	
<i>Printed Name of Representative and Relationship</i>	<i>Representative's Address and Telephone Number</i>	
_____	_____	
<i>Date</i>	<i>Signature of Witness</i>	

ORIGINAL – Atlanta Neurology Records; COPY - Individual

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