191 Roswell Street
Suite 200
Marietta, GA 30060
404-526-9955

315 West Solomon Street
Suite 140
Griffin, GA 30223
678-603-1119

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Health Record No.: _____ S.S.N.: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

Name:_____

Address:_____

3. The type and amount of information to be used or disclosed is as follows:

___ Problem List

___ Medication List

___ List of Allergies

___ Immunization Record

___ Most recent history and physical

___ Most recent discharge summary

___ Laboratory results from (date) _____ to (date) _____

___ X-Ray and Imaging Reports from (date) _____ to (date) _____

___ Consultation Reports from (Doctor Name) _____

___ Entire Record from (date) _____ to (date) _____

___ Itemized Billing Statement from (date) _____ to (date) _____

___ Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

THE GRAHAM LAW FIRM
315 W. Solomon Street, Suite 140
Griffin, GA 30223

for the purpose of: _____***PERSONAL INJURY CLAIM***_____.

6. I understand I have the right to revoke this Authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this Authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this Authorization will expire at the conclusion of my personal injury claim, whether by settlement or litigation. If I fail to specify an expiration date, event or condition, this Authorization will expire in six (6) months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided on CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have any questions about disclosure of my health information, I can contact my health providers directly.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative Signature of Witness
Relationship to Patient