Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Legal Name	Birthdate	Social Security No. *(optional)*
Address		
City	State	Zip Code

INFORMATION TO BE RELEASED TO (Requestor)

Name Steven M. Lobel, MD	
Address 320 Hospital Road	
City Canton State GA Zip 30114	

Facility authorized to release PHI

Name	
Address	
City State Zip.	

Fax 770 479 8821 Phone 770 479 5535 **If I fail to specify an expiration date or event, this authorization will expire (12) months from the date on which it was signed.**

Purpose of disclosure:

❑Medical Care ❑Legal ❑Insurance ❑Personal ❑Other _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED **Starting** _____ **Ending** _____

	Starting Date	Ending Date		Starting Date	Ending Date
❑ All PHI in the medical records			❑ Consultation Reports		
❑ History and Physical Reports			❑ Discharge Summary		
❑ Progress Notes			❑ Itemized Billing Statement		
❑ X-Ray Tests/Reports			❑ Patient Information Form		
❑ Laboratory Reports			❑ Other Specified:		

The Protected Health Information listed below <u>WILL BE</u> released when included in the above medical information unless specifically indicted otherwise.

Psychiatric/Mental Information
Alcohol/Drug/Substance Abuse Information
AIDS/HIV/Genetic Information
OTHER _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I understand that I have the right to revoke this authorization at any time in writing and must present the written revocation to the provider authorized to release the protected health information. I understand if I do revoke this authorization it will not apply to information that has already been released to this authorization.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorized the disclosure of the protected health information as stated:

(1) Patient Signature_____ Date:

(1) **PATIENT REPRESENTATIVE SIGNATURE (IF APPLICABLE)**	2)**(RELATIONSHIP TO PATIENT** Date: