Blairsville Internal Medicine

374A Pat Haralson Drive PO Box 1000 Blairsville, GA 30514 706-745-5541 FAX 706-745-0282

AUTHORIZATION FOR BIM TO RELEASE MEDICAL INFORMATION

PATIENT ______________________ DATE OF BIRTH ____________________ CHART ______________________

I hereby authorize use and/or disclosure of protected health information (PHI) about me as described below. By signing, I authorize **Blairsville Internal Medicine** to disclose certain PHI about me to:

NAME____

ADDRESS____

CITY STATE ZIP ____

Phone #: ___________________________________ FAX #: ___________________________________

The specific information to be disclosed is:

_____The contents of my medical file, specifically: the most recent office notes, laboratory data, problem list, medication list, procedure reports, x-rays or medical records which may have been obtained from another source. I acknowledge that the information I am requesting may contain information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information.

_____Other (please specify): ____

The information will be used or disclosed for the following purpose:

_____To aid in the diagnosis and/or continuing treatment of the patient.

_____Other (please specify): ____

Blairsville Internal Medicine will _____ will not _____ receive payment for the authorized copies.

This authorization expires one year from the date I enter below, or by notifying the releasing organization in writing of my desire to revoke (cancel) it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign it.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

____ _____________________________
SIGNATURE of Patient, Legal Guardian or Healthcare Proxy DATE

____ DOB ____________________ SSN ____________________
Printed Name of Legal Guardian or Healthcare Proxy

Patient/Guardian must be provided with a signed copy of this authorization form.