

Blairsville Internal Medicine

Patient Name _____ DOB _____ CHART _____

Authorize Records Release from Another Provider

I hereby authorize release/disclosure of protected health information (PHI) about me as described below. By signing, I

authorize _____ (Provider/PracticeName)

_____ (Address, City, Zip)

_____ (Phone and Fax)

to disclose PHI about me to

Blairsville Internal Medicine Mail to: PO Box 1000 Blairsville, GA 30514
FAX TO: 706-745-0282

The information to be disclosed is:

_____ The contents of my medical file, specifically: 1) the problem list, medication list, and most recent office notes; and 2) laboratory data, procedure reports, x-rays or tests results obtained within the last year.

_____ Other (please specify): _____

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

_____ To aid in the diagnosis and/or continuing treatment of me as a patient.

_____ Other (please specify): _____

I understand that this disclosure may include information regarding alcohol and drug abuse/treatment, psychological and social work counseling, HIV or AIDS or ARC, communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis, and demographic information.

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

Printed Name of Legal Guardian or Healthcare Proxy DOB SSN

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