# AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Today's Date: _____

Patient Name: _____Date of Birth:_____

Address:_____

I authorize _____ (current medical provider) to use or disclose my health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):
   **_X__**The entire medical record (all information)
   ____ Minimum Data Set
   ____ Business Office File
   ____ Nursing documentation/Progress Notes
   ____ Physician and Professional Consult Progress Notes
   ____ Diagnostic reports (lab, x-ray, etc.)
   ____ History and physical
   ____ Medication and treatment records
   ____ Other (Describe as specifically as possible):
   _____
2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):
   **Name: Elite Family Medicine**
   **Address: 850 Brookstone Centre Parkway**
   **Columbus, GA 31904**
   **Phone Number: 706-507-5320**
   **Fax Number: 706-507-4747**
3. **Purpose of use/disclosure –** My complete medical record will be disclosed to the physician listed above and will be used to continue my medical treatment.
   **__X** Initiated at the request of the patient.
   ____ My personal records
   ____ Sharing with other health care providers as needed
   ____ Other (please describe):

**Authorization Statements/Signatures:**

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
5. **For Marketing disclosures only: *(Check if applicable)*** _____I understand that will receive compensation related to the use or disclosure of the requested information.
6. I understand that I have a 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 _____(physician) I understand that the revocation will not apply to information that has already been released in response to this authorization.
7. Unless I specify differently, this authorization will expire 1-year from date of signature. I understand that _____will not condition the provision of treatment or payment on the provision of this authorization.

Form, Format, and Manner of Access:
**___XX___**Electronic, ____Paper, _____CD, _____Email, _____I wish to pick up my records.

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient Printed Name