



# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**Patient Name:** \_\_\_\_\_ **Patient Record Number:** \_\_\_\_\_

Last                      First                      Middle

**Date of Birth (mm/dd/yyyy):** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_

**I understand this information will be [ ] disclosed to or [ ] obtained from:**

**Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_

**The purpose for such disclosure is:**

Further Medical Care    Changing Physicians    Insurance Eligibility/Benefits    Personal    Legal Investigation or Action    Web Site

Television Broadcast    Radio Broadcast    Newspaper    Periodical    Newsletter    Brochure    Announcement

Marketing/Public Information Activities \_\_\_\_\_

Other (specify): \_\_\_\_\_

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

**Information to be released:**    Entire Record    Only the parts of the medical record that I specify: \_\_\_\_\_

Photographic Image/Picture    Audio/Voice Recording    Videotape or Film Recording    Interview (written or verbal)    Other: \_\_\_\_\_

**Privilege Box**

In compliance with applicable laws, the information listed below **cannot be released without my specific consent and knowledge**. Therefore, I have initialed (no other mark is acceptable) before each type of record that I authorize you to release:

\_\_\_\_\_ Alcohol and/or drug abuse treatment records                      \_\_\_\_\_ AIDS, HIV, or HIV testing records                      \_\_\_\_\_ Genetics

\_\_\_\_\_ Mental Health treatment records                      \_\_\_\_\_ Sexually transmitted diseases records

**Your Rights With Respect To This Authorization:**

**Right to Inspect or Copy the Health Information to Be Used or Disclosed** – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information by contacting the Privacy Officer at (678) 784-1085. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Privacy Officer at (678) 784-1085. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. I hereby release the Cobb County Board of Health and/or the Douglas County Board of Health, its employees, its agents, and its staff physicians from all liability and all claims of any nature pertaining to the lawful disclosure of the information described above.

**Expiration Date:** This authorization is effective until the following date \_\_\_\_\_ or 90 days from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**Name (please print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Witness name (please print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

**Picture identification shown (specify):** \_\_\_\_\_

**Date requested:** \_\_\_\_\_ **Date completed:** \_\_\_\_\_

**Records**   [ ] mailed   [ ] picked up   **Number of pages:** \_\_\_\_\_ **Charge:** \_\_\_\_\_