Authorization To Release

North Georgia Endocrinology

Name:_____ **Date of Birth:** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information policy laws.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To inspect or copy the protected health information to be used or disclosed.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To refuse to sign the authorization.
- To a statement that covered entity may receive remuneration from use or disclosure of requested information.
- To a copy of this form.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for actions taken before receipt of my written notice to revoke this authorization or if the covered entity had taken action in reliance thereon. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

I (the patient) am requesting that you (North Georgia Endocrinology) may release the following information regarding my health information to:

(Appointment Information, Medical Records, or Health Information)

- ***Please list the name of Person(s) to whom we may release information*:**

  Name_____ **(Relationship to patient)** _____
  Name_____ **(Relationship to patient)** _____
  Name_____ **(Relationship to patient)** _____

- ***Please identify the information that may be released to this person*:**

  _____**Appointment Information** _____**Treatment Information** _____**Health Information** _____**Account Information** _____**All of the Above**

- ***May we leave a message/contact you regarding***

	Home Phone	***Work Phone***	***Cell Phone***
Appointments:	**Yes/No**	**Yes/No**	**Yes/No**
Lab Results	**Yes/No**	**Yes/No**	**Yes/No**
Office Information	**Yes/No**	**Yes/No**	**Yes/No**

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, of (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I have had the chance to read and think about the consent of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/ or disclosure of the protected health information described in this form with the people and/or organization named in this form.

X_____ _____

Signature of Patient or Legal Representative Date