AUTHORIZATION FOR USE/RELEASE OF PROTECTED HEALTH INFORMATION

This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purpose.

Name of Patient _____ **Date of Birth** _____

Street Address _____

I authorized the use and/or release of my protected health informatiion as described below. I understand this authorization is voluntary and is made to confirm my instructions

AUTHORIZATION TO RELEASE FROM:

_____

_____

_____

Phone _____

Fax _____

RELEASE PROTECTED HEALTH INFORMATION TO:

_____

_____

_____

Phone _____

Fax _____

HEALTH INFORMATION TO BE RELEASED FOR THE FOLLOWING INCLUDE :

In compliance with Georgia Statutes that require special permission to release otherwise privileged information, please **INITIAL** if protected information being released includes: *(Check those are to be released)*

- ☐ Mental Health records
- ☐ Substance Abuse records
- ☐ All Medical records
- ☐ Medication Compliance
- ☐ Treatment Summary
- ☐ Developmental Disabilities
- ☐ HIV (AIDS)

Compliance and Discharge date and reason for discharge/ Continuing Care Recommendations / Verbal Communication/ Telephone Calls: (Specify Names) (Please give a clear description or explanation)

Other: (Please give a clear description or explanation)

_____

_____

PURPOSE OR NEED FOR DISCLOSURE : *(INITIAL all that apply. You must initial at least ONE)*

- ☐ Further Medical Care
- ☐ Insurance Eligibility/Benefits
- ☐ Legal/Legislative Issues
- ☐ Disability Determination
- ☐ Other: *(Specify)* _____

EXPIRATION:

This authorization becomes effective ____/____ /____ except to the extent of action already taken. Unless earlier revoked by me, this authorization automatically terminates one (1)year from the effective date. This will expire one (1) year from the date of my signature below. I further understand that if I am under a criminal justice system referral this cannot be revoked by me until there has been a formal and effective termination or revocation of my release from probation or parole or other proceeding under which I was mandated for treatment.

UNDERSTANDING AND SIGNATURE:

I understand that this authorization does not extend to release of any HIV/Aids information unless I have indicated above. I further understand that the information authorized by this Release will be released to the authorized recipient only for the purpose noted above. I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I understand that I am entitled to receive a copy of this authorization.

Signature of Patient or Legal Guardian _____ **Date** _____

If a representative on behalf of a consumer signs authorization complete the following:

Regal guardian Name : _____ **Relationship to Patient:** _____

(FORM MUST BE COMPLETE) PLEASE SEE REVERSE FOR IMPORTANT INFORMATION

Notice to Recipient : This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR Part 2)and/or state law. In accordance with federal and state law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than authorized herein without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate, prosecute any alcohol or drug patient.

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

Provider recognizes the patient's right of confidentiality of their health information under federal privacy regulations and Georgia law. The patient should be aware of the following information when requesting or releasing health information.

Right to Refuse to Sign This Authorization:

A patient may refuse to sign this Authorization and this refusal will not affect the patient's ability to obtain treatment or payment of claims.

Right to Inspect or Copy the Health Information to be Used or Disclosed:

A patient has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A patient may arrange to inspect his/her health information by contacting the office listed below.

DR SUNITA GUPTA MDPC
370 Prospect Place
Alpharetta, GA 30005

Right to Receive Copy of This Authorization:

A patient has the right to receive a copy of the signed Authorization form.

Right to Revoke This Authorization:

A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer listed below. Revocation of this Authorization will not affect any action taken in reliance of this authorization before receipt of the written notice or revocation.

Multiple Releases of Information:

A patient may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the consumer's signature. A new Authorization is necessary for release of information for care provided after the date of the patient's signature, unless the authorization specifically states that specific records that will be generated in the future may be released: for example, "Future records of a specific test," or "Future records of specific clinic appointment."

Who May Sign This Authorization:

Generally, all patients 18 years of age and older must sign for release of their own health information unless the following conditions apply:

A. The patient is incompetent
B. The patient is disabled and cannot sign the form
C. The patient is deceased. (The legal representative of the estate may sign)

All persons signing for release of health information on behalf of the consumer must state their relationship to the consumer and provide proof of legal authority of their capacity to act for the consumer.

Minors:

Consumers less than 18 years of age must have the signature of a parent or guardian ad litem to sign for release of their health information. Emancipated minors may sign for release of their health information

Fees for Records:

Provider may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on applicable laws governing release of health information.

Contact Office:

Requests for release of health information can be directed to the Medical Records Clerk or other appropriate staff representative at the office where the services were provided. All questions regarding federal privacy regulations can be directed to:

DR SUNITA GUPTA MDPC
370 Prospect Place
Alpharetta, GA 30005

Mail Requests for Records

Authorization forms that are mailed to your Provider must be notarized unless the form is one that is generated by a federal or state entity(such as Social Security).

Authorization Signed at Office:

Unless office staff knows the person signing the form, picture identification will be required at the time the form is signed. Provider makes every effort to provide records as requested within 10 business days.
Federal law requires that we respond to requests for records within 30 days. If records are stored off premises, we will provide records within 60 days.