HIPAA AUTHORIZATION FORM

Authorization for Disclosure of Protected Health Information (PHI)
(Patient's Permission to Release Information in the Medical Record)

Patient Name:_____ **Last Four of SSN**: _____

Previous Names: _____ **Date of Birth:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Email Address: _____ **Phone #:**_____

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Request Information From:

Provider/Facility Name:

Address:

City/State/Zip:

Phone:

Fax:

Release Information To:

Name/Facility: Premier Chronic Pain Care- Dr. Rasean T. Hodge

Address: 619 Boulevard NE

City/State/Zip: Atlanta GA 30308

Phone: 404.895.1924 Fax: 888.291.6290

- The providing provider/facility has my permission to use or give out certain information in my medical record — called "protected health information" (PHI). The information that providing provider/facility may give out is checked below.

- I also understand that PHI may include information protected under Federal and State Law (such as information about alcohol, drug abuse, mental health, HIV, and/or AIDS treatments).

Information to be Released

☐ Clinic Progress Notes	☐ Discharge Summary	☐ Lab Reports	☒ All Records
☐ Hospital Progress Notes	☐ EKG/Cardiology Reports	☐ Radiology Reports	☐ HIV/AIDS
☐ History and Physical	☐ Pathology Reports	☐ Radiology Images	☐ Mental Health Care or
☐ Consultation Notes	☐ Operative Reports	☐ Psychotherapy Notes	☐ Services
☐ ED Notes	☐ Other:_____		

☐ Diagnosis, Treatment and/or Referral for Alcohol and/or Drug Abuse

Release Format: ☒ Paper ☐ CD/DVD **Release Method:** ☒ Mail ☐ Pick-up ☒ Fax 888.392.6290

Expiration of Authorization
I understand that I may revoke this authorization at any time by sending a written notice to Premier Chronic Pain Care /Dr. Rasean T. Hodge at the address noted below. I understand that the revocation will not apply to any PHI that has already been released in association with this authorization.

Right to Revoke Authorization
This authorization will expire one (1) year from the date of signing unless I revoke it in writing, or indicate an event or earlier date here: _____

ATTENTION: Please review the information below carefully. If information is missing, the request may not be processed.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older, and lacks the capacity to sign**, a legally authorized person may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form. Please indicate your relationship: ☐ Parent ☐ Legal Guardian
- **If the patient is deceased,** the patient's legal next of kin or authorized representative must sign and date the form.

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I have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person with permission to act on Patient's behalf. I will not hold the provider and/or facility, its officers,trustees,employees,agents,or contractors responsible for anything that may happen from the use or release of my PHI.

Print Patient Name	**Date Signed (required):**
Patient Signature	
Print Patient's Authorized Representative Name, if under 18 (minor)	**Date Signed (required):**
Signature of Patient's Authorized Representative, if under 18 (minor)	

(Note: Please give a copy of the signed Authorization to Patient)

Documentation Required to Release Medical Records

To ensure we have verified the identity of the patient, we ask that you make the following documentation available to us with this request.

Patient's Requesting Medical Records

- Authorization for Disclosure of Protected Health Information form signed by the patient.
- Government issued photo identification (Driver's License, State ID card, Passport).

Patient's Representative Requesting Medical Records (caregiver/guardian for minor under 18)

- Authorization for Disclosure of Protected Health Information form signed by the patient's representative.
- Government issued photo identification of the patient's representative (Driver's License, State issued ID card, Passport)
- Durable Medical Power of Attorney if NOT patients guardian