AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The following individual(s) or organization is authorized to make the disclosure:

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❑ complaints and diagnosis
- ❑ list of medication
- ❑ list of allergies
- ❑ immunization records
- ❑ most recent medical and/or physical history from _____to _____
- ❑ most recent discharge summary from _____to _____
- ❑ laboratory results from _____to _____
- ❑ x-ray and imaging reports from _____to _____
- ❑ consultation reports from _____
- ❑ **entire medical/dental/psychiatric/psychological record**
- ❑ other _____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. It is my intention by this authorization to comply with Georgia law requiring my full and informed consent for otherwise privileged information.

6. This information may be disclosed in person, telephonically, electronically, or in writing to and used by the following individual or organization:

Laurie M. Thomas Williams
Reed Thomas Law Group, LLC
P.O. Box 1798
Pine Lake, GA 30027
Lmt@reedthomaslaw.com

For the purpose of a pending legal action.

7. It is expressly understood that any information released to the law firm named above may be used only by that law firm or individuals the firm retains or consults with in preparation of the pending action and may not be released to any other person without my or my attorney's prior written consent.

8. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: conclusion of the pending action. If I fail to specify an expiration date, event or condition, this authorization will expire in six months. I authorize that a photocopy or facsimile of this document be accepted with the same force and effect as the original.

9. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact *(name of firm and contact information)*

_____ _____

Parent's Name Date

_____

Relationship to Patient