

Buckhead Injury Wellness Institute

HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

TO: _____

RE: Patient's Full Legal Name: _____
Date of Birth: _____
SSNumber: _____

Pursuant to HIPAA Standards for Privacy of Individually Identifiable Health Information, 45. C.F.R §§ 164.512 & 164.508, I hereby authorize you to use or disclose the above referenced patient's health information, as described below. I further authorize **BUCKHEAD INJURY WELLNESS INSTITUTE 5825 Glenridge drive Bldg 2 STE 212 Atlanta Georgia 30328** to receive such health information.

The purpose of the requested use of disclosure is:

- At the request of the individual for purposes of health information**
 Other (please specify) _____

The information to be used or disclosed includes the following specified information:

- Complete Medical Record** for any and all dates and service (including information related to patient's identity, diagnosis, prognosis and/or treatment, which may include substance abuse, mental health, and or HIV/AIDS information), OR
 Specifically, the following:

___ Discharge Summary	___ Consultation Reports	___ Radiology MRI/CT/X-Rays
___ ER Records	___ History and Physical	___ Operative Report
___ Lab Reports	___ Progress Notes	___ Psychiatric Notes
___ Records from other providers	___ Office Notes/Visits	(Subject to uncombined authorization)
___ Meds/Pharmacy Records		

Treatment Period (specify) _____

I understand that the information in the above-referenced patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. I authorize the release of such information, with the following exceptions: _____

I understand that if this authorization is sought by a covered entity, I will be given a copy of this authorization form after signing it. The original or photo static copy hereof may be accepted as genuine by said physician, medical attendant, hospital, or other persons or institutions, and by any agents or representatives thereof.

___ (Initial if applicable) I acknowledge receipt of my copy of my medical record.

Patient Signature

Date