Buckhead Injury Wellness Institute (B.I.W.I.)

Buckhead Injury Wellness Institute 5825 Glenridge Dr Bldg 2 STE 212
Atlanta Ga, Office: 404.537.3452• Fax: 404.256.2627

Patient: _____
Address: _____
_____
Phone: _____
Email: _____

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPESENTATIVE

Consent for use of **P**rotected **H**ealth **I**nformation (**PHI**)

By checking YES, I am authorizing The Injury Wellness Institute to acknowledge my patient status or discuss my protected health information with the following family members and/or friends. YES ☐

By checking NO, I am requesting T.I.W.I. not to acknowledge that I am a patient or to release any protected health information to anyone other than my referring and/or primary care physician and myself. NO ☐

I have agreed to let certain individuals participate in discussion and decisions related to my medical care. Therefore, I hereby give my permission for The Injury Wellness Institute and Physician on duty and his/her staff to disclose my personal health care information to the following individual(s):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Name: _____D.O.B._____
Print Name

Patient Signature: _____Date_____

Revocation of Personal Information Release

At this time I no longer wish for my PHI to be discussed with anyone other than myself. By this statement I wish to revoke the above authorization with any of the above named individuals.

Patient Signature: _____Date: _____