Atlanta Personalized Medicine

David F. Rodriguez, MD

Authorization for Disclosure of Protected Health Information

Atlanta Personalized Medicine LLC (hereafter referred to as APM) is authorized to disclose the following information from the health records of:

Patient Name:	
Date of Birth:	
Address:	
Telephone:	

This information is to only be disclosed to:

Name:	
Date of Birth:	
Address:	
Telephone:	

Date of Treatment: or Range of Dates From: To:
For the purpose of: _____

The following information is to be released: _____

I understand that this will include information relating to (check and initial, if applicable): Acquired immunodeficiency syndrome (AIDS); Human immunodeficiency virus (HIV) infection; Behavioral Health service/psychiatric care; Treatment for alcohol and/or drug abuse

Affirmation of Release: I give APM permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost**. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer be protected by the regulations.
You are entitled to a copy of your medical records under most circumstances after providing the physician with a signed release and paying the required fees as set by state law. **For more information visit: https://dch.georgia.gov/medical-records-retrievalrates.

_____ _____
Signature of the Patient/Guardian/Legal Representative Date Signed

_____ _____
Signature of Witness/Relationship to Patient Date Signed

Expiration date: _____ (One year from date signed)