Georgia Breast Care

# Authorization to Release Protected Health Information

**Patient Name (print):** _____ **DOB:** _____/_____/_____ **Phone:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Last 4 of SSN#**__ __ __ _

**I authorize representatives from Georgia Breast Care, PC to disclose my individual identifiable protected health information (PHI) in this request to the organization, agency, or patient named in order to maintain continuity of care with other providers and/or seek reimbursement on my behalf. I may refuse to sign this authorization and is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. In addition, I release Georgia Breast Care, PC, its employees, officers, agents, and physicians from any legal liability for disclosure of protected health information. I understand that I may revoke this consent at any time at any time in writing except to the extent that action has been taken based on this authorization. This authorization form will expire 90 days from the date of authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. A copy or fax of this authorization will be as valid as the original. I understand that the information to be disclosed may include any or all information involving communicable or veneral disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses – HIV/AIDS.**

***Release Records/Information FROM:*** *(Check one)*

☐ Georgia Breast Care
780 Canton Rd NE Suite 410
Marietta, GA 30060
Phone: (678)370-0370 Fax: (678)370-0371

☐ Name: _____
Address: _____
City/St/Zip: _____
Phone: _____ Fax: _____

***Release Records/Information TO:*** *(Check one)*

☐ Georgia Breast Care
780 Canton Rd NE Suite 410
Marietta, GA 30060
Phone: (678)370-0370 Fax: (678)370-9497

☐ Name: _____
Address: _____
City/St/Zip: _____
Phone: _____ Fax: _____

***Protected Health Information allowed to be included:***

- ☐ Mammogram Reports (Current & Past 2 years)
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Genetic Testing
- ☐ Patient Progress Notes
- ☐ Operative Reports
- ☐ Other: _____ (please specify)

***Purpose of Disclosure:***

- ☐ Personal Request
- ☐ Further Medical Care
- ☐ Insurance
- ☐ Legal Action
- ☐ Disability
- ☐ Other: _____ (please specify)
  - ☐ I will pick up my medical records in person.
  - ☐ I authorize _____ to pick up my medical records in person. Relationship: _____

_____ _____

***Signature of Patient/Authorized Representative*** ***Date***

*The personal health information contained on this form is intended only to aid in providing healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such. If you have received this form in error, please contact our office at (678) 370-0370 located at 780 Canton Road NE, Suite 410, Marietta, Georgia 30060 and shred this document.*