AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may be re-disclosed and may no longer be protected by federal privacy regulations.

Patient name: _____ **Account Number**: _____ **DOB:** _____

Persons/Organizations authorized to release the information: Nissi Family Medicine

Persons/Organizations authorized to receive the information: _____

***** MUST BE COMPLETED BY PATIENT ******

Specific description of information (including date(s)):

_____ Copies of all medical records for the period ___/___/____ to ___/___/____
Mo Day Year to Mo Day Year

_____ Copies of information described below for period ___/___/____ to ___/___/____
Mo Day Year to Mo Day Year

_____ History & Physical Examination _____ Lab, X-ray, etc.

_____Reports and/or notes from other physicians (circle which is needed) Name of physician of outside records is required.

_____ Other (Please specify) _____

I understand that my records may contain certain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented and therefore will be released:

_____ _____
Signature **Date**

The patient or the patient's legal representative must read and initial the following statements:

1. I understand that this authorization will expire upon fulfillment of this request. Initials: ____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have an effect on any actions taken before the organization received the revocation. Initials: ____

Send revocations to Privacy Office: Nissi Family Medicine,
1810 Mulkey Road, Suite 105, Austell, Georgia 30106

To be completed by the Practice:
1. The purpose of the use or disclosure is: ___at request of patient ___life insurance ___ other _____

2. The information will be used in the following manner: See attached request/ or _____

3. The Practice ☐ will ☐ will not receive direct or indirect remuneration or compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: The patient or the patient's legal representative may inspect and/or copy the protected health information to be disclosed in accordance with the Practice's access policies.
The Practice does not limit its right to make a use or disclosure of your information that is required by law or permitted to avert a serious threat to the health or safety to the public.

Signature of patient or patient's legal representative: _____ _____
Date

Printed name of patient's representative: _____

Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION - THE PRACTICE WILL NOT CONDITION TREATMENT OR PAYMENT ON THE PROVISION OF THIS AUTHORIZATION