

Urban Family Practice Associates, P.C.

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 redisclosed and may no longer be protected by federal privacy regulations.

Patient name: _____ Account Number: _____ DOB: _____
Persons/Organizations authorized to release the information: Urban Family Practice Associates, P.C.
Persons/Organizations authorized to receive the information: _____

******MUST BE COMPLETED ******

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

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

Or ____ 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) _____

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, Urban Family Practice Associates P.C.,
2520 Windy Hill Road, Suite 301, Marietta, Georgia 30067

*****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.

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

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: Date

Relationship to patient:

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