Atlanta Specialized Care
Authorization to Release/Receive Health Information

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purposes.)

By signing this form, I authorize ASC
To: release or receive_____ (circle one or both and initial and date) the protected health information described below:

Name of Person and/or Organization to Whom Information Should be Sent and/or Received from:
_____

Address/Phone #/Fax # of Person/Organization to Whom Information Should Be Sent or Received from:
_____

Please send this information on or about (information will not be resent without another authorization):
____/____/____
This authorization expires upon fulfillment of request unless special circumstances noted below **
_____
Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):
_____
I authorize the following information to be sent to the address above:

___ Copies of all medical records for the period ___/___/____ to ___/___/____
___ Copies of the information described below for period ___/___/____ to ___/___/____
___ History & Physical Examination ___ Lab, X-ray, etc. Reports ___ Reports from Other Physicians
___ Other (Please Specify)

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should *not* be released, even if occurring during dates above:

__

**** Please describe any special requirements such as Faxing, certified mail, extended expiration date, and the like:**

I understand that there may be information in these records that I would not want released.

I have been provided a copy of ASC's *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with ASC's Privacy Officer or other appropriate office personnel.

I understand that ASC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release ASC from all legal liability that may arise from this authorization.

Patient Name: _____

Patient's Signature_____Date_____
SS# _____ DOB:_____
If the signature above is not that of the patient, I am acting for the patient because
_____
My relationship to the patient is: _____.
Signed _____
The patient or their representative may revoke this authorization by notifying in writing ASC's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to disclosure by the recipient.