NEWNAN
FAMILY MEDICINE ASSOCIATES, P.C.

AUTHORIZATION TO RELEASE HEALTH RECORDS

I, _____ hereby voluntarily authorize the disclosure of information from my health record.

Patient's Name: _____ Patient's Date of Birth: _____

Patient's SSN: _____

Information requested from: _____

Phone No.: _____ Fax No. _____

Purpose of release: _____

_____

The information is to be provided to:

Name of Person/Organization/Facility: _____

Address: _____

Phone No. _____ Fax No. _____

1. I understand that this authorization will expire on (date): _____
2. I understand that I may revoke this authorization (except the extent that action was already taken in reliance on this signed authorization) at any time notifying Newnan Family Medicine Associates in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's or Patient's Representative's Signature **Date**

_____ _____

Printed Name of Patient or Representative **Relationship to Patient**

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM
Under HIPAA with Patient's written request, records must be provided within 30 days of request.
HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state, laws.