HIPAA AUTHORIZATION FOR THE USE AND
DISCLOSURE OF HEALTH INFORMATION

TO: _____

RE: _____

Patient's Full Legal Name: _____

Date of Birth: _____

Medical Records # (or S.S. #): _____

Address: _____

Telephone: _____

Pursuant to HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§164.512 & 164.508, I hereby authorize you to use or disclose my protected health information, as described below. I further authorize the following individuals or organizations to receive such health information: Sessions & Fleischman, LLC. The purpose of the requested use or disclosure is: At the request of the individual for purposes of investigation or litigation;

The information to be used or disclosed includes the following specified information:

_____ Medical Record during approximate time period from _____ to _____ (including information related to my identity, diagnosis, prognosis and/or treatment, which may include substance abuse, mental health, and/or HIV/AIDS information).

_____ Discharge Summary
_____ ER Records
_____ Nursing Notes
_____ Operative Report
_____ Pathology Report
_____ Diagnostic Studies
_____ Office Notes/Visits
_____ Medication(s)/Prescriptions
_____ Consultation Reports
_____ History and Physical
_____ Progress Notes/Orders
_____ Lab Reports
_____ Radiology Reports
_____ Media Files
_____ Billing Records
_____ Records from other providers
_____ Hospital Chart (Entire)
_____ Psychiatric Notes (subject to uncombined authorization)
_____ Other (specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse.

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may by re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing any substance abuse information under the federal confidentiality requirements for alcohol and drug abuse patient records and the Public Health Service Act. Such information may not be used to criminally investigate or prosecute any alcohol or drug patient. Further, pursuant to O.C.G.A. § 24-9-47, state law prohibits a recipient from making any further disclosure of test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains. A general authorization for the release of medical or other information is NOT sufficient for such purpose.

I understand that I have the right to revoke this Authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand that if this Authorization is sought by a covered entity I will be given a copy of this Authorization form, after signing it.

Signature of Patient/Authorized Representative:

_____ Date: _____

Patient