Intown Family Practice & Sports Medicine, PC / Records
1078 Piedmont Ave NE, #102, Atlanta, GA 30309
Fax: (404) 719-5325
email: IntownFPSM@aol.com

Authorization For Use/Disclosure of Protected Health Information

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
Patient Address: _____ Phone: _____
City/State/Zipcode: _____

DISCLOSURE: Records are to be disclosed to Piedmont Healthcare.

Piedmont Physicians at Midtown
1080 Peachtree Street NE, Suite 12
Atlanta, GA 30309
Phone: 404-253-3660 Fax: 404-253-3661

PURPOSE: Transfer of records for continuing medical care

DESCRIPTION OF INFORMATION FOR RELEASE:
❑ Entire Chart or limited to the following: _____

APPLICABLE DATES OF SERVICE: ❑ All ❑Other:_____

This authorization permits Intown Family Practice & Sports Medicine, PC (IFPSM) to use and/or disclose the above described individually identifiable health information about me. I understand that this authorization is specific to the information, purpose and date(s) of services indicated above. I further understand that this authorization is valid for 180 days from the date below and will expire at that time unless another date is written here:_____

I understand that the information that I am authorizing IFPSM to use/disclose may include information related to the diagnosis or treatment of mental illness, substance abuse, chemical dependency. and alcohol abuse, including privileged psychiatric or psychological communications and other detailed mental health information; Infectious diseases, such as HIV/AIDS, sexually transmitted infections, tuberculosis or hepatitis; and genetic testing or information derived from genetic testing. I hereby waive any privilege concerning such information for the disclosure to the person or entity I have authorized above. I understand that the information used/disclosed pursuant to this authorization will not include psychotherapy notes, which are notes recorded by a mental professional documenting or analyzing contents of conversation during a counseling session that are kept separate from the rest of the medical records.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations.

I understand that unless otherwise limited by state or federal regulations, I may revoke this authorization at any time by presenting my revocation in writing to IFPSM/Records, except to the extent that IFPSM has taken action in reliance on this authorization.

_____ _____
Patient or Legal Representative Signature Please PRINT name

_____ _____
Relationship to Patient Date/time