HOMECARE MEDICINE *of* ATLANTA

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize the health care providers of **HomeCare Medicine of Atlanta (HCMA)** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

Telephone number: _____

Fax Number: _____

Purpose: I authorize the release of my health information for the following specific purpose:

_____
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ☐ Only the following records or types of health information:

_____
_____
_____

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

3330 Cumberland Blvd.
Ste 500
Atlanta, GA 30339
www.hcmatl.com

1.800.609.7494 Office
1.770.740.2611 Local
1.770.800.3100 Fax
info@hcmatl.com

HOMECARE MEDICINE *of* ATLANTA

Term: I understand that this Authorization will remain in effect:

- ❑ For 30 days from the date indicated on this form OR
- ❑ Until the Provider fulfills this request.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at HCMA. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the HCMA Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Fee: I understand that if released to me, my request for medical records will incur a $25 processing fee that will be collected along with this signed form BEFORE the records are released. If released directly to the third party, there is no fee.

Questions: I may contact the HCMA Office for answers to my questions about the privacy of my health information.

_____	_____	_____
Signature	Date	Signature of Witness

If the patient is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Printed Name of Guardian	Legal Relationship	Date	Signature

3330 Cumberland Blvd.
Ste 500
Atlanta, GA 30339
www.hcmatl.com

1.800.609.7494 Office
1.770.740.2611 Local
1.770.800.3100 Fax
info@hcmatl.com