

West Atlanta Internal Medicine, P.C.

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AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

The HIPAA Privacy Rules (federal regulations that became effective April 14, 2003) provide important protection for health information including that your authorization is obtained in certain circumstances. The Privacy Rules apply to the use and disclosure of Protected Health Information (PHI) by entities providing medical care and treatment.

Name: _____

Social Security #: _____

Date of birth: _____

From: _____

Phone: _____ **FAX:** _____

Address: _____

To: West Atlanta Internal Medicine, P.C.

Specific information needed:

Complete -Pap & pelvic records - Lab results - Medical notes/summary - HIV/AIDS
X-ray report X-ray films - Alcohol or substance abuse - Mental health
Psychotherapy records - Other (please specify)

Purpose for this disclosure:

Continuing medical treatment Insurance Other (please specify)

I understand that my personal health information may include medical records created or received by medical practitioners, including records regarding general medical care; alcohol and substance abuse treatment; psychiatric/psychological treatment; social work counseling; and information regarding communicable diseases and infections, which can include venereal disease, tuberculosis, HIV, AIDS Related Complex, and claims and billing information. I authorize the release of this information to the individuals or organizations listed above only under the conditions listed below. This authorization does extend to psychotherapy records, as that term is defined in the HIPAA Privacy Rules, 45 C.F.R. § 164.501, to mean notes recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during private, joint or group counseling sessions, and which are kept separate from my medical record. If not revoked, this authorization is valid until it expires six months from the date signed below or until the following date or event: I understand that I may revoke this authorization at any time, but I must do so in writing and send to Privacy Officer, Sindecuse Health Center, Western Michigan University, Kalamazoo, MI 49008-5445. The revocation will not be effective to the extent that the Sindecuse Health Center has already disclosed the information. Understand that the information disclosed is subject to re-disclosure and will no longer be protected by the federal Privacy Rules, 45 C.F.R. Parts 160 and 164. I understand that I have the right to receive a copy of this authorization after it has been signed. A copy or fax of this authorization may be used in lieu of this original.

SIGNATURE: _____