ATLANTA DIABETES ASSOCIATES
ENDOCRINE SPECIALTY GROUP

1800 Howell Mill Rd NW Ste 450
Atlanta, GA 30318
Phone 404-355-4393
FAX 770-727-3362

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ hereby request and authorize _____
_____ the name of the hospital, or physician name if requesting release from a physician's office) to use or disclose medical records as described below.

Purpose of Use or Disclosure: _____ At the request of the individual

____ Other _____

Patient's Full Name: _____ SS# _____

Maiden /Other Name: _____ Telephone Number (Home) _____

Date of Birth: _____ Telephone Number (Work) _____

Current Address: _____

I further request and authorize use or disclosure of the medical records checked below to (please provide name, address, phone, and fax number):

_____
_____
_____
_____

This Authorization applies to the information checked below for the following date or dates of service: _____
_____

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

_____ Entire Medical Record _____ Financial Record _____ Office Notes

_____ Laboratory Test Results _____ Medication Record _____ Treatment Plan

_____ EKG Report _____ Other – specify _____

_____ Note- specify _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure 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 except to the extent that the entity identified above has taken action in reliance on this Authorization. You may pick up a revocation form from the Medical Records Department and return it there after you have completed and signed it. I further understand that the Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose writ1en above. Atlanta Diabetes Associates shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in stances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

I further understand that this Authorization is valid for a period of 90 days from today's date and will expire at that time unless another date is written here; _____

_____ _____ _____

Patient s or Legal Representative Signature | Please Print Name | Today's Date

As a legal Representative, my relationship to the patient is _____. Any document outlining such authority should be attached. The patient is unable to sign because _____

There may be fees for provision of any or all request information

1800 Howell Mill Rd NW Ste 450
Atlanta, GA 30318
404-355-4393 Phone
404-609-7648 Fax

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Atlanta Diabetes Associates** to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and health care operations (TPO). Atlanta Diabetes Associates' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta Diabetes Associates reserves the right to revise its Notice of Privacy Practices at any time. **A revised Notice of Privacy Practices may be obtained by forwarding a written request to Atlanta Diabetes Privacy Office at 1800 Howell Mill Rd, Suite 450, Atlanta, GA 30318.**

With this consent, Atlanta Diabetes Associated may call my home, send e-mail or mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. These items include but are not limited to appointment reminders, insurance items, corespondence from the physicians, - any calls pertaining to clinical care, including laboratoryy results, and patients statements.

I have the option to request that Atlanta Diabetes Associates restrict how it uses discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restricted, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Atlanta Diabetes Associates' use and disclosure of my PHI to carry out TPO with those organization and health providers necessary for my medical care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. IfI do not sign this consent, or later revoke it, Atlanta Diabetes Associates may decline to provide treatment to me.

I further understand that this Authorization is valid for a period of 90 days from today's dare and will expire at that time unless another date is written here;_____

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's name (Print) Date

There may befees for provision of any or all request information