Fax to #_____

HEADLEY FAMILY MEDICINE
825 South First Street - Jesup, Georgia 31545
Phone 912-427-7400 - Fax 912-385-2953

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient_____
Date of birth_____SS#_____Phone _____
Street Address_____
City, State, Zip_____

I hereby authorize _____ to disclose my protected health information as indicated below to *HEADLEY FAMILY MEDICINE*.

Information to be released:

From & To Dates_____	
History & Physical Exam	_____
Lab Reports	_____
X-Ray Report	_____
Consultation Report	_____
Other	_____

Purpose of Disclosure:

Changing Physicians	_____
Continuing Care, Second Opinion	_____
Patient's request	_____
Workers' Compensation, Insurance	_____
Other	_____

1. This authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original
2. I may revoke this authorization any time by notifying Susan Collins, Privacy Officer, at the address above in writing and this authorization will cease to be effective on the date notified except where action has already been taken.
3. This information used or disclosed with this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, the other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. Refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I may have a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this authorization.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____
Relationship to Patient

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric, disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

* Substance Abuse (Including alcohol/drug abuse)
* Mental Health
* Psychotherapy Notes
* HIV-related information (including AIDS-related testing)

The confidentiality of this record is required under Chapter 899 of Connecticut General Statutes, as well as, Title 42 of the United States Code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

_____ _____
Signature of Patient or Legal Guardian Date