HEADLEY FAMILY MEDICINE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(This form applies only to the release and disclosure of information. It is not acknowledgement for treatment or intended for any other purposes.)

By signing this form, I authorize ______________________________________ to release health information described below to: FAX#

HEADLEY FAMILY MEDICINE
William V. Headley, Jr., MD, FAAFP
825 South First Street
PO Box 606
Jesup, GA 31598
Phone 912-427-7400
Fax 912-385-2953

I authorize you to release copies of all medical records from ______________ to present

I understand that provider of records assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release the provider from all legal liability that may arise from this authorization.

Patient's Signature: ____

Date: _____/_____/_____

SS#: ____________________________ DOB: ___________________

If the signature above is not that of the patient, I am acting for the patient because: __________________

____

My relationship to the patient is: __________________________________

Signed: _____________________________________

The patient or their representative may revoke this authorization by notifying in writing the providing practice's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.