Larry W. Anderson, D.O.

ANDERSON
FAMILY MEDICINE

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ____________

By signing this authorization, I authorize Anderson Family Medicine to use and/or disclose certain protected health information (PHI) about me to:

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(Name, address and phone/fax of entity to receive this information)

This authorization permits Anderson Family Medicine to use and/ or disclose the following identifiable health information (specifically describe the information to be used or disclosed, such as date(s) of service, types of service, level of detail to be released, origin of information, etc.):

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This authorization will expire on ______________ (please allow at least 1 week).
When my information is used or disclosed pursuant to this authorization, it may subject to re disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon authorization.

Signed by: ______________________________ ______________________________
Signature of Patient or Legal Guardian — Relationship to Patient

______________________________ ______________________________
Patient Name (if different from above) — Date

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Print Patient Name or Legal Guardian

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#AFM001
Piedmont Graphics 08/22/14