AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security Number: _____
Date of Birth: _____

1. I authorize the use of disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

Provider: _____
Address: _____
_____

3. The Provider listed above is requested to disclose the records I have checked below only for the period of time from _____ to Present .

- ✓ Assessment, Admission and Triage Records
- ✓ Physician's Orders and Notes
- ✓ History and Physical
- ✓ Clinical and SOAP Notes
- ✓ Laboratory/Pathology Reports
- ✓ Medication Records
- ✓ X-ray, CT, MRI, PET, SPECT, Ultrasound
- ✓ Arthroscopic, and any other imaging **reports**
- ✓ Physical and Occupational Therapy Records
- ✓ Entire Records
- ✓ Other _____
- ✓ Patient Intake Records
- ✓ Nursing Notes
- ✓ Operative Records
- ✓ Discharge Summary
- ✓ Diagnostic Testing Records
- ✓ Chiropractic Records
- ✓ Consultation and IME Reports
- ✓ Photographs of the Patient's Body
- ✓ Arthroscopic, and any other imaging **films**
- ✓ Entire Patient Expense and Billing Information

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by my Attorneys for the purpose of legal representation:

Law Office of Harold W. Whiteman, Jr.
2500 Cumberland Pkwy, Suite 240
Atlanta, Georgia 30339

Telephone: (404) 963 9393 Fax: (404) 963-9876

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire in six (6) months**.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rule.

8. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.

Signature of Client or Legal Representative	Date
If signed by Legal Representative, Relationship to the Client	Signature of Witness