MedLink Georgia

Location: _____

AUTHORIZATION TO USE OR DISCLOSURE PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient Address: _____ SSN: _____

Email:_____

Phone Number: _____ Alternate Phone:_____

By signing below, you hereby authorize MedLink to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose(s) and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.
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Information to be used or disclosed must be identified in a specific and meaningful fashion.
Unless indicated by specific request checked below, I permit the release of any and all information held by MedLink including, if any, information concerning drug/alcohol abuse records, venereal disease and other statutorily protected diseases, psychiatric records (excluding psychotherapy notes), or AIDS/HIV testing and/or treatment records.

Please Initial Specific Protected Health Information Authorized for Release:

□ *All PHI in medical record*	□ ** Psychotherapy Notes*	□ *ER Reports*
□ *Discharge Summary*	□ *Operative Report*	□ *X-Ray Reports*
□ *History & Physical*	□ *Video/Photo*	□ *Pathology Report*
□ *Progress Notes*	□ *Laboratory Reports*	□ *Treatment Plans*
□ *Medical Records*	□ *Physician's Orders*	□ *PKU / Metabolic screen*
□ *Immunization Records*	□ *Newborn Discharge Summary*	□ *Other (Specify)*

****If this is a request for psychotherapy notes, then this is the only item that may be requested on this Authorization. You must submit another Authorization for other information.***

The purpose of the use and disclosure of this information is for

□ Medical Treatment & coordination of care □ Other (Please specify):

Information that may not be used or disclosed includes _____

Information that *may not be used or disclosed includes*
FROM the doctor, office, facility, or provider listed below
Name:

Address:

Phone: Attn:

TO the doctor, office, patient, agency, legal representative or entity listed below
Name:

Address:

Phone: Attn:

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

Format to receive information: □ E-mail □ Electronic data □ Paper

_____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am: _____

_____

O-510
(09-13)