

PLEASE COMPLETE TO HAVE YOUR RECORDS COPIED

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Note: Form **MUST** be completed before signature is obtained)

PATIENT NAME _____
LAST
FIRST
MI
MAIDEN

DATE OF BIRTH _____ / _____ / _____ SS# _____ - _____ - _____ MEDICAL RECORD # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DAY PHONE _____ EVENING PHONE _____

<input checked="" type="checkbox"/> I authorize WellStar Health System to disclose my protected health information as indicated below to:			
<u>Adult Medicine of Marietta, P.C. (Drs. Hoffman, Griffith, Mills and Lenhard)</u> <i>Name of entity to receive this information</i>			
790 Church Street, Suite 250	Marietta	Georgia	30060
ADDRESS	CITY	STATE	ZIP
678-797-8201	678-290-8325		
PHONE NUMBER	FAX NUMBER		

INFORMATION TO BE RELEASED	PURPOSE OF DISCLOSURE
<ul style="list-style-type: none"> • Medication List, Problem List, Immunization Form and Diabetic Flowsheet • Office notes for the last one year • Most recent EKG, Echo, Exercise/Nuclear Stress Test • X-ray reports for the last one year • Lab reports for the last one year • Most recent spirogram/PFT • Any drug/alcohol, AIDS/HIV, STD, mental health information • Other _____ 	<input checked="" type="checkbox"/> Continuing Care

I understand that this authorization will expire: 6 months from date signed
Expiration Date or Defined Event

I understand that my health care and the payment for my health care will not be affected if I do not sign this form and that I may refuse to sign it. **INITIALS** _____

I understand that I may revoke this authorization at any time by notifying WellStar Health System in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization. **INITIALS** _____

I understand that a charge may be incurred to copy these records. **INITIALS** _____

 Signature of Patient or Legal Guardian

 Date