

DOB: _____

SS: _____

(one or the other please)

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Georgia Colon & Rectal Surgical Associates, P.C. is authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipients) of that information. I specifically authorize any current employee or owner of Georgia Colon & Rectal Surgical Associates, P.C., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (*check all that apply*):

The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed).

The patient's demographic information (check all that apply):
 Name Address State/Zip Code only Telephone
 Age Gender Race Other:

Medical Data/Information as related to:
 Specific condition(s):
 Specific professional service(s):
 Specific medication(s):
 Other:

Other:

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's protected health information:

Names) or class of persons) authorized by this form who may use and disclose the patient's protected health information:

Purpose(s) of the information

(Check if applicable) This authorization is to be used for our own use, and Georgia Colon & Rectal Surgical Associates, P.C. will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

(Check if applicable) The patient understands that Georgia Colon & Rectal Surgical Associates, P.C. may receive financial gain as a result of disclosing this information due to or copy the information to be used or disclosed and may refuse to sign this authorization.

(Check if applicable) This authorization permits Georgia Colon & Rectal Surgical Associates, P.C. to send the protected health information ONLY to this address or fax number: & ATTN

Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Georgia Colon & Rectal Surgical Associates, P.C. must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Georgia Colon & Rectal Surgical Associates, P.C. will accept written revocations of this authorization via:

Certified U.S. mail

Facsimile at this number:

ALL revocations must be sent to Georgia Colon & Rectal Surgical Associates, P.C. to the attention of the Privacy Officer, Tammie Fraser, and are not effective until received by the Privacy Officer.

This authorization shall expire on _____ . After this date, Georgia Colon & Rectal Surgical Associates, P.C. can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient's Signature

Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____