Clayton Family Medicine
Brian Pratt, MD

458 N. Main St. Clayton, GA 30525
Phone: (706) 960-9550
Fax: (706) 960-9551

AUTHORIZATION TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION

(PRINT) Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of my protected health information as described.

1. Physician Name/Health Facility authorized to disclose protected health information.

_____

_____

Phone: _____ Fax: _____

2. Please release medical records to Clayton Family Medicine
3. Reason why protected health information is needed: **CONTINUATION OF CARE**
4. I wish for this authorization to remain effective for the time period of one year.
5. Please include all records applicable to the following time frame
   - ____ Most recent visit
   - ____ Visit dated _____
   - ____ One Year of Records
   - ____ Three Years of Records
   - ____ Five Years of Records
6. Information to be disclosed:
   - ____ Physician Office Notes
   - ____ Laboratory Reports
   - ____ Imaging Reports
   - ____ Test Results (EKG, ECHO, Etc.)
   - ____ Hospital Records
   - ____ Other (specify) _____
   - ____ Immunization Records
7. The following items must be initialed to be included in the use or disclosure of your protected health information:
   - ____ HIV/AIDS related information
   - ____ Mental Health Information
   - ____ Drug/Alcohol diagnostics, treatment or referral information

(Federal regulations require a description of how much and what kind of information is to be disclosed)

Please describe: _____

8. I understand that I have the right to revoke this authorization by submitting a request in writing.

* _____ * _____

Signature of Patient or Legal Representative | Print Patient Name | Date

_____

Print Name of Legal Representative (if applicable) | Relationship to Patient | Date