AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release all medical records including history, finding, and prognosis to Athens Orthopedic Clinic, P.A. A copy shall be as valid as the original document.

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (i) to the extent that The Practice has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Privacy Official/Committee at *1765 Old West Broad Street, Bldg 2, Ste 200, Athens, GA 30606*, by sending a written request stating that I wish to revoke this Authorization to the attention of the Privacy Official/Committee. I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. By signing this authorization, I authorize *ATHENS ORTHOPEDIC CLINIC, P.A. & GEORGIA SPORTS MEDICINE INSTITUTE* (the "Practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed above.

RECORDS FROM:

_____
Facility Name

_____ _____
Phone Fax

SENT TO: Physician: _____

ATHENS ORTHOPEDIC CLINIC, P.A.
1765 OLD WEST BROAD ST *706-549-1663 (Phone)*
BUILDING 2, SUITE 200 *706-546-8792 (Fax)*
ATHENS, GA 30606

PATIENT NAME: _____ DOB: _____

SOCIAL SECURITY: _____ PHONE #: _____

_____
Signature of Patient or Legal Representative

_____
Printed (legible) Name of Patient or Legal Representative

_____
Date Signed

If signed by Legal Representative, please check one:
- ☐ Relationship to this patient: _____
- ☐ Custodial Guardian
- ☐ Durable Power of Attorney for Healthcare