
**Athens Orthopedic Clinic**
**1765 Old West Broad Street, Bldg. 2, Athens, GA 30606**

## Request for Access to / Authorization for Use and Disclosure of Protected Health Information

Name: _____
(First) (Middle) (Last) (Maiden/Other Name)

Date of Birth:_____ Phone #:_____ Medical Record #: _____

Address:_____ City:_____ St:_____ Zip: _____

**I hereby authorize Athens Orthopedic Clinic, PA to disclose my Protected Health Information to:**

Name:_____ Attn: _____

Address:_____ City:_____ St:_____ Zip: _____

Relationship: _____ Phone:_____ Fax:_____

**RECORD DELIVERY METHOD (select one):**
☐ Mail (via US Postal Service)
☐ Pick up at Athens Orthopedic Clinic
Person picking up records: _____
Email: _____

**INFORMATION TO BE RELEASED / DATES OF INFORMATION:**
☐ Medical Records
☐ Billing Records
☐ Diagnostic Films
☐ Other: _____

**I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING TO:**
☐ Substance abuse (including alcohol / drug abuse)
☐ Mental health or behavioral health
☐ HIV related information (AIDS related testing)
☐ Genetic testing

**PURPOSE OF DISCLOSURE:**
☐ School ☐ Research ☐ At request of patient
☐ Changing physicians ☐ Consultation
☐ Insurance / Worker's Compensation
☐ Legal (specify):
☐ Other (specify): _____

_____ _____
Signature of patient or personal representative Date

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

I understand that the expiration date of this authorization is _____, or if no date is specified it will expire 90 days after the date of signature. 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; or (iii) there is other law that grants the insurer the right to contest a claim under the policy. Written notification must be provided to the Practice's Privacy Official / Committee at the address provided on this document. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations. By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand that if I am being requested to authorize a use or disclosure that, upon request, I will get a copy of this form after I sign it. I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law. I understand that I may be required to pay the cost of creating paper copies or electronic media, mailing copies, supervising my inspection, or preparing a summary except for uses and disclosure for the purpose of treatment, payment and operations.

The cost of copies of your medical records for your personal use is **$6.50 per request, made payable to** AOC **and due in advance.** If the request is for continuing care and your records are provided directly to a physician or healthcare provider, all fees associated with the release of information will be waived. **All questions regarding your records are to be directed to** AOC Medical Records **at (706)549.1663 x3206**

I acknowledge and understand terms of this **Request for Access to / Authorization for Use and Disclosure of Protected Health Information**.

Patient / Legal Representative signature:_____ Date: _____

Relationship to Patient: _____

**INVOICE METHOD:**

MAIL: _____ FAX TO:_____ EMAIL TO:_____ OTHER:_____

Continuing Care (No Charge):_____ Personal Use ($6.50):_____ XRays /CD($10.00)_____

Payment Type: Cash_____ Check:_____ Credit:_____ Payment Received By:_____
(Print Name)