WEST
GEORGIA
DERMATOLOGY

PMS ID

Authorization for Use and Disclosure of Protected Health Information to a Spouse or Other Individual

This form authorizes West Georgia Dermatology and its designated representatives to use and disclose your Protected Health Information ("PHI") to your spouse or other individual described below, for a purpose other than treatment, payment, or health care operations and at your request. You only need to complete this Authorization if you want West Georgia Dermatology to disclose your PHI to your spouse or another individual to whom you authorize us to disclose your PHI. PHI is information that identifies you as a West Georgia Dermatology patient and relates to your past, present, or future physical or mental health condition and related health services.

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Individuals Authorized to Receive PHI from West Georiga Dermatology

Name of Person to Receive PHI	Relationship to Patient	Address	Telephone Number	Duration of Authorization

☐ I authorize West Georgia Dermatology to release my entire medical and billing records. I understand that checking this box authorizes the use or disclosure of all information in my medical and billing record including, demographic information, pathology results, imaging reports, laboratory reports, prescription history, and other sensitive information.

☐ I authorize West Georgia Dermatology to release only the following information from my medical and billing records:

_____

☐ I authorize this information to be disclosed electronically, if requested.

I understand that I may refuse to sign this Authorization. I also understand that information released to the person(s) authorized above may be subject to re-disclosure by the recipient and may no longer be protected by Federal and state privacy regulations. I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. This Authorization shall remain effective indefinitely, unless otherwise stated above or revoked by me by providing written notice to West Georgia Dermatology addressed to the: ***Privacy Officer****, 109 Professional Pl, Carrollton, GA 30117. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.*

Please send completed form to your provider using the secure link on our website or fax to (770) 838-7755.

_____ _____

Signature of Patient Date