HIPAA AUTHORIZATION FORM FOR DISCLOSURE OF MEDICAL RECORDS

I, _____, GIVE PERMISSION TO WINDER INTERNAL MEDICINE AND GERIATRIC CENTER TO:

DISCLOSE (RELEASE) THE FOLLOWING PROTECTED HEALTH INFORMATION (CHECK ONE):

___ ALL MEDICAL RECORDS

___ OTHER: _____

_____

INDIVIDUALS TO WHOM INFORMATION MAY BE DISCLOSED (RELEASED):

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

I, _____, GIVE PERMISSION TO WINDER INTERNAL MEDICINE AND GERIATRIC CENTER TO:

DISCLOSE (RELEASE) MY BALANCE AND/OR INSURANCE INFORMATION REGARDING MY TREATMENT AT WIMGC TO THE FOLLOWING INDIVIDUALS:

_____

_____

IF THE PERSON OR ENTITY RECEIVING THIS INFORMATION IS NOT A HEALTH CARE PROVIDER OR HEALTH PLAN COVERED BY FEDERAL PRIVACY REGULATION, THE INFORMATION DESCRIBED ABOVE MAY BE DISCLOSED TO OTHER INDIVIDUALS OR INSTITUTIONS AND NO LONGER PROTECTED BY THESE REGULATIONS.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. YOUR REFUSAL TO SIGN WILL NOT AFFECT YOUR ABILITY TO OBTAIN TREATMENT OR PAYMENT OR YOUR ELIGIBILITY FOR BENEFITS.

FINALLY, YOU MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME BY SENDING WRITTEN NOTIFICATION TO CARRIE WARREN AT 20 SATELLITE DRIVE, SUITE 100, WINDER, GA 30680. YOUR NOTICE WILL NOT APPLY TO ACTIONS TAKEN BY THE REQUESTING PERSON/ENTITY PRIOR TO THE DATE THEY RECEIVE YOUR WRITTEN REQUEST TO REVOKE AUTHORIZATION.

_____

SIGNATURE OF PARTICIPANT OR PERSONAL REPRESENTATIVE/DATE

_____

PRINTED NAME OF PARTICIPANT OR PERSONAL REPRESENTATIVE

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY