FIRST LOOK PRIMARY CARE, P.C.

A REVELATION IN QUALITY HEALTHCARE

Authorization of release of Medical Records and/or disclose protect Health Information

Patient Name (please print) _____ Date of Birth _____

Home Address, City, State, and Zip code _____

Dr. Janis Anthony-Wade, D.O
Physician

I hereby authorize the use/disclosure of my protected information as described below.

1. The information that may be used or disclosed is the following.

___ All of my protected information including privileged information (HIV/AIDS, psychological, drug/alcohol information)

___ All of my protected information with the exception of privileged information.

___ Other (describe a specific and meaning of fashion)

2. The information will be used or disclosed for the following purpose:

___ As a request by me

___ Other (describe): _____

3. Persons/Organizations authorized to disclose (release) the information:

Physician/Facility: _____

Address, City, State, Zip Code: _____

Telephone: _____ Fax: _____

4. Person/Organization authorized to receive/disclose the information. (Check)

___ **First Look Primary Care, P.C. 2766 Atlanta Hwy Gainesville GA. 30504**

5. This authorization will expire (check one):

___ 90 Days

___ When I revoke this authorization in writing as described below

___ Other expiration event that relates to your or the purpose of the use/disclose:

I understand that any information disclosed pursuant to this authorization may be subject to disclose by the recipient and may no longer be protected by federal privacy regulations (HIPAA). I understand that I may revoke this authorization in writing at any time by sending the revocation to FLPC Medical Records Dept., expect that action has been taken in reliance on this authorization. Aside from this I understand that upon expiration of the authorization, no further use or disclosure of the information may be made. I understand that I may be declined treatment if I refuse to sign this authorization only when: (1) the treatment is for the sole purpose of creating a protected health information for disclosure to a third party pursuant to this authorization, or (2) the treatment is related to a research project health and this authorization ID for the use/disclosure of information for such research. I understand that I may inspect or copy the information used/disclosed.

_____ _____

Signature of Individual or Individual's representative Date

_____ _____

Print Name of Legal Rep. (If applicable) Relationship of Legal Rep. to Individual

(Copy of this signed for will be provided to the individual and/or the individual's legal representative upon request)

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