PATIENT AUTHORIZATION FORM

TO: _____
_____
_____

FROM: Internal Medicine of Griffin, LLP
231 Graefe Street
Griffin, GA 30224
Ph: 770-227-1587 Fax: 770-227-1485

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

**Description of the specific information to be used or disclosed:

_____
_____
_____

**Person or entity requesting the information and authorized to make the requested use of disclosure:

_____
_____

*Recipient of the information: _____

**This information is being requested for the following purpose(s):

_____
_____
_____

This authorization shall remain in effect from the date signed below until
1 YEAR (expiration date or event)

I understand that:

* I may inspect or copy the protected health information to be used or disclosed
* I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
* Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the Recipient and no longer be protected by HIPPA
* I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment).

Patient Name: _____ Signature: _____

DOB: _____

Relationship to Patient
(If signed by personal representative of Patient): _____ Date: _____