



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient (please print):

Birth Date:

Street Address:

City, State Zip Code

To disclose my protected health information, to:

Name:

Street Address:

City, State, Zip Code:

Phone:

I hereby authorize:
Dr. Gerald K. Brantley
Dr. Terry E. Ham Jr.
1023 Keith Drive
Perry, Georgia 31069

PHONE: (478) 988-1100
FAX: (478)988-8211

Information to be released:

- Medical History, Examination Reports
- Treatment or Tests
- X-Ray Reports
- Laboratory Reports
- HIV Test Results *
- Mental Health
- Sexually Transmitted Diseases*
- Alcoholism

- Surgical Reports
- Hospital Records including Reports
- Developmental Disabilities
- Prescriptions
- Consultations
- Allergy Records
- Drug Abuse
- Other (Please specify) _____

* A listing of the statutory exceptions to release HIV/STD test results without consent is available.

Purpose for Need of Disclosure:

- At the request of the individual.
- Other (Please Specify) _____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- > **Receive A Copy of This Authorization.**
- > **Refuse To Sign This Authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- > **Revoke This Authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): **30 days after dated signature below.**

Signature of Patient (or Legal Representative)

Date

If signed by Legal Representative:

Relationship to Patient (Authority to act on patient's behalf)

Date: