Buckhead Injury Wellness Institute

HIPAA AUTHORIZATION

FOR USE/DISCLOSURE OF HEALTH INFORMATION

TO: _____

RE: Patient's Full Legal Name: _____
Date of Birth: _____
SSNumber: _____

Pursuant to HIPAA Standards for Privacy of Individually Identifiable Health Information, 45. C.F.R §§ 164.512 & 164.508, I hereby authorize you to use or disclose the above referenced patient's health information, as described below. I further authorize **THE INJURY WELLNESS INSTITUTE 5825 Glenridge Dr. bldg. 2 STE 212** to receive such health information.

The purpose of the requested use of disclosure is:
☐ **At the request of the individual for purposes of health information**
☐ **Other** (please specify) _____

The information to be used or disclosed includes the following specified information:
☐ **Complete Medical Record** for any and all dates and service (including information related to patient's identity, diagnosis, prognosis and/or treatment, which may include substance abuse, mental health, and or HIV/AIDS information), OR
☐ **Specifically**, the following:

____Discharge Summary
____ER Records
____Lab Reports
____Records from other providers
____Meds/Pharmacy Records
____Consultation Reports
____History and Physical
____ Progress Notes
____Office Notes/Visits
____Radiology MRI/CT/X-Rays
____Operative Report
____Psychiatric Notes
(Subject to uncombined authorization)

Treatment Period (specify) _____

I understand that the information in the above-referenced patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. I authorize the release of such information, with the following exceptions: _____

I understand that if this authorization is sought by a covered entity, I will be given a copy of this authorization form after signing it. The original or photo static copy hereof may be accepted as genuine by said physician, medical attendant, hospital, or other persons or institutions, and by any agents or representatives thereof.
____ (Initial if applicable) I acknowledge receipt of my copy of my medical record.

_____ Date _____
Patient Signature

5825 Glenridge Dr, Bldg 2 STE 212 30328
404.537.3452 Office 404-531-9600 Fax