AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Shyla Reddy, MD
Alpha Family Medicine Inc
480 North Main Street, Suite 202
Alpharetta, GA 30009
Ph: 678-619-1974
Fax: 678-619-1975

I hereby authorize the disclosure of information from my health record:

Patient Name (or Alias)

Date of Birth ( ) Phone

Address

City, State, Zip

You may obtain healthcare information FROM:

Clinic/Hospital Provider Name

Address

City, State, Zip

( ) ( )

Fax Telephone

You may send healthcare information TO:

Name (i.e. Self, Attorney, Provider)

Address

City, State, Zip

( ) ( )

Fax Telephone

If requesting birth records, include mother's name at time of patient's birth: _____

Type of Information requested (check all that apply):

□ Emergency Report □ Medication □ Verbal □ Other Imaging (MRI, Echo, Nuclear)
□ Operative Report □ History & Physical □ Discharge Summary □ Progress (Chart) Notes
□ Lab □ EKG □ X-ray □ Consultation □ Other _____

If above section is not completed, responses to record requests will contain a record abstract of the two (2) most recent years from the last date of service. This will include: History and Physical, Discharge Summary, Operative/Procedure Reports, Emergency Room Report and test results.

Specific Dates of Treatment: _____

Purpose for which information is being released (check one):

□ My doctor/Continuation of care □ Myself □ Insurance claim □ Legal □ Other (specify) _____

I understand that:

- ✓ This authorization, unless expressly limited by me in writing, **will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse, and mental health conditions**.
- ✓ This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- ✓ I am not required to sign this authorization in order to receive treatment at Swedish, except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party.
- ✓ Any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Expiration Date or Event: _____

*Authorization for disclosure to a financial institution or employer of the patient for purposes other than payment for healthcare services expires (90) ninety days from the date signed, unless otherwise specified.

_____ _____
Patient Signature **Date**

_____ _____ _____
or Legal Representative **Relationship**