AUTHORIZATION FOR USE/RELEASE OF PROTECTED HEALTH INFORMATION

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purposes.)

Complete in full. See reverse side for important information.

1. _____ (name of consumer)_____
(birth date)

_____
(street address) (city, state, zip code)

I authorize the use and/or release of my protected health information as described in Section 4 below. I understand this authorization is voluntary and is made to confirm my instructions.

I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization.

Authorization for the Release of Information:

I hereby request and authorize: Joseph Berger, MD, RPh
3 Dunwoody Park • Suite # 118
Atlanta, GA 30338-7404
Off) 770- 730-8912 • Fax) 770-390-0877
www.josephbergermd.com

To Request From &/or Release To:

X: _____
Name

_____
Street Address

_____
City, State, Zip

X: _____
Phone

_____
Fax

4. HEALTH INFORMATION TO BE RELEASED:

√ **All Medical Records** □ Other (for other information give clear description)_____
□ Lab Reports _____
□ Billing Records – Specify_____

4a In compliance with Georgia Statutes that require special permission to release otherwise privileged information, please release records pertaining to:

√ **Mental Health** □ Developmental Disabilities
□ Alcohol Abuse □ Drug Abuse
□ HIV (AIDS) □ Other_____

5. PURPOSE OR NEED FOR DISCLOSURE: (You must check at least one.)

√ **Further medical care** √ **At the request of the consumer** □ Legal/investigative
□ Insurance eligibility/benefits □ Vocational rehabilitation evaluation □ Summary report
□ Disability determination □ Other_____

6. EXPIRATION
This authorization will expire on_____/_____/_____ (MM/DD/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below.

7. SIGNATURE:
I have had full opportunity to read and consider the contents of this Authorization and I confirm that the contents are consistent with my direction to the health care provider. I understand that by signing this form, I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of the consumer, complete the following:

Representatives Name:_____

Relationship to Consumer:_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT
SEE REVERSE SIDE FOR IMPORTANT INFORMATION

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

Joseph Berger MD recognizes the consumer's right of confidentiality of their health information under federal privacy regulations and Georgia law. The consumer should be aware of the following information when requesting or releasing health information:

- **Right to Refuse to Sign This Authorization:** A consumer may refuse to sign this Authorization and this refusal will not affect the consumer's ability to obtain treatment or payment of claims.
- **Right to Inspect or Copy the Health Information to be Used or Disclosed:** A consumer has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A consumer may arrange to inspect his/her health information by contacting the office listed below.
- **Right to Receive copy of This Authorization:** A consumer has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer listed below. Revocation of the Authorization will not affect any action taken in reliance of this authorization before receipt of the written notice of revocation.
- **Multiple Releases of Information:** A consumer may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the consumer's signature. A new Authorization is necessary for release of information for care provided after the date of the consumer's signature, unless the authorization specifically states that specific records that will be generated in the future may be released, for example "future records of a specific test": or "future records of specific clinic appointment."
- **Who May Sign This Authorization:**
    1. Generally, all consumers 18 years of age and older must sign for release of their own health information unless the following conditions apply:
        a. The consumer is incompetent
        b. The consumer is disabled and cannot sign the form
        c. The consumer is deceased. (The legal representative of the estate may sign.)
    2. All persons signing for release of health information on behalf of the consumer must state their Relationship to the consumer and provide proof of legal authority of their capacity to act for the consumer.
    3. Minors: Consumers less than 18 years of age must have the signature of a parent or guardian ad litem to sign for release of their health information. Emancipated minors may sign for release of their health information.

Fees for Records Joseph Berger, MD may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing release of health information.

Contact Office: Requests for release of health information can be directed to Joseph Berger, MD at the office where the services were provided. All questions regarding federal privacy regulation can be directed to:

Joseph Berger, MD, RPh
3 Dunwoody Park Suite 118
Atlanta, Georgia 30338
Office: (770) 730-8912

Mailed Requests for Records: Authorization Forms that are mailed to Joseph Berger, MD must be notarized unless the form is one that is generated by a federal or state entity (such as Social Security).

Authorization Signed at Office: Unless office staff knows the person signing the form, picture identification will be required at the time the form is signed.

Joseph Berger, MD makes every effort to provide records as requested within 7 business days. Federal law requires that we respond to requests for records within 30 days.. If records are stored off premised, Joseph Berger, MD will provide records within 60 days.