SANDY SPRINGS
SSIM
INTERNAL MEDICINE

Authorization for Disclosure of Protected Health Information

I hereby authorize Sandy Springs Internal Medicine, P. C. (hereafter referred to as SSIM) to disclose the following information from the health records of:

Patient Name:		
Date of Birth:	Last four digits SSN#:	
Telephone (H):	(W):	(C):
Address:		

This information is to only be disclosed to:

Name:		
Address:		
City:	State:	Zip:
Phone: ( )	Fax: ( )	

Date of Treatment: or Range of Dates from: To:

For the purpose of:

The following information is to be released:_____

I acknowledge and hereby consent to the release of information relating to: psychiatric records, psychotherapy notes, alcohol and/or drug abuse records; HIV/AIDS information; genetic testing, and/or sexually transmitted disease information (if applicable). **Please initial:** _____

If you do not wish to release any of the categories of information described above, please specify:

_____

Affirmation of Release: I give SSIM permission to release only the information selected on this form to the individual/agency listed above and only for the purposes I have indicated. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person/entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer be protected by the regulations.

_____ _____
Signature of the Patient/Guardian/Legal Representative Date Signed

_____ _____
Signature of Witness/Relationship to Patient Date Signed

Expiration date: _____ (One year from date signed)

Sandy Springs Internal Medicine, P.C.
755 Mt. Vernon Highway, N.E. Suite 500 • Atlanta, Georgia 30328 • Phone (404) 256-9544 Fax (404) 252-3720
www.ssim.com