PMS ID

NEWNAN • PEACHTREE CITY • WEST GEORGIA

DERMATOLOGY

Authorization for Use and Disclosure of Protected Health Information to a Spouse or Other Individual

This form authorizes Dermatology Specialists of West Georgia, P.C. and its designated representatives to use and disclose your Protected Health Information ("PHI") to your spouse or other individual described below, for purposes including but not limited to treatment, payment, or health care operations and at your request. You only need to complete this Authorization if you want Dermatology Specialists of West Georgia, P.C. to disclose your PHI to your spouse or another individual to whom you authorize us to disclose your PHI. PHI is information that identifies you as a Dermatology Specialists of West Georgia, P.C. patient and relates to your past, present, or future physical or mental health condition and related health services.

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Individuals Authorized to Receive PHI from West Georiga Dermatology

Name of Person to Receive PHI	Relationship to Patient	Address	Telephone Number	Duration of Authorization

☐ I authorize Dermatology Specialists of West Georgia, P.C. to release my entire medical and billing records. I understand that checking this box authorizes the use or disclosure of all information in my medical and billing record including, demographic information, pathology results, imaging reports, laboratory reports, prescription history, and other sensitive information.

☐ I authorize Dermatology Specialists of West Georgia, P.C. to release only the following information from my medical and billing records:

☐ _____
I authorize this information to be disclosed electronically, if requested.

I understand that I may refuse to sign this Authorization. I also understand that information released to the person(s) authorized above may be subject to re-disclosure by the recipient and may no longer be protected by Federal and state privacy regulations. I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. This Authorization shall remain effective indefinitely, unless otherwise stated above or revoked by me by providing written notice to Dermatology Specialists of West Georgia, P.C. addressed to the: ***Privacy Officer****, 112 Wilshire Village Dr, Peachtree City, GA 30269. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.*

Please send completed form to your provider using the secure link on our website or fax to (770) 838-7755.

_____ _____

Signature of Patient Date