Authorization for Use/Release of Health Information

By signing this form, I authorize _____ to release or disclose the protected health information described below to:

Dr. Crandall M. Chambers
811 22nd Street
Columbus, GA 31904 **Ph: (706) 323-1054** **Fax: (706) 327-6270**

Please send this information on or about ___/___/___ (Please be advised this information will not be shared without further authorization.)

This authorization expires upon fulfillment of request unless special circumstances are noted below.

Purpose of disclosure (at the request of patient, continuity of care, insurance, etc.) _____

I authorize that the following information be sent to the address above:

___ Copies of all medical records for the period ___/___/___ to current or specifically

___ H&P ___ Labs, X-rays, other reports ___ Reports from other physicians on ___/___/___.

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health services/psychiatric care, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should NOT be released, even if occurring during the dates above:

_____

_____

_____

I have provided a copy of Crandall M. Chambers, M.D., LLC's *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Crandall M. Chambers, M.D., LLC's Privacy Officer or other appropriate office personnel.

I understand that Crandall M. Chambers, M.D., LLC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Crandall M. Chambers, M.D., LLC from all legal liability that may arise from this authorization.

Patient's Signature _____ **Date** _____

Patient's SSN _____ **Patient's DOB** _____

If signature is not that of the patient, I am acting for the patient because _____.
My relationship to the patient is _____ Signed _____

The patient or their representative may revoke this authorization by notifying in writing Crandall M. Chambers, M.D., LLC's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal law also requires a statement that there is the potential for the protected health information released under this authorization my be subject to redisclosure by the recipient.

For office use only:

Visits billed?: _____ YES _____ NO Initials:_____