AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patient's Full Name:_____
SS Number:_____ **Date of Birth:**_____
Current Address:_____
_____

Persons/Organizations authorized to receive the information:

Zevin & Rosenbloum, P.C.
Suite 4550
191 Peachtree Street, N.E.
Atlanta, Georgia 30303

Persons/Organizations authorized to make disclosure:_____

The purpose of this disclosure is to pursue an insurance claim.

Requested Date(s): From_____ To_____
Specific Description of PHI use/disclosure:
____ Entire Medical Records*
____ Complete Financial Records

*The Information used/disclosed to this authorization will not include psychotherapy notes, but may include other detailed mental health information, HIV/AIDS information and /or information regarding alcohol or substance abuse.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. The Providers shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or instances where the sole purpose of creating the health information is for disclosure to a third party.

This authorization and/or request to release information from my protected health information (PHI) is fully understood and is made voluntarily on my part and includes faxing of PHI. I understand that a photostatic or faxed copy of this authorization is valid as the original.

I further understand that this Authorization is valid for 1 year from today's date and will expire at that time unless an earlier date is written here _____.

_____ _____
Patient's or Legal Representative's Signature Today's Date