Infectious Disease Specialists of Atlanta, P.C.

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PATIENT AUTHORIZATION FOR PRACTICE RELEASE/REQUEST

By signing this authorization, I authorize Infectious Disease Specialists of Atlanta, P.C. to release/request certain protected health information (PHI) about me to the party or parties listed below.

Provide copies to: _____

Request copies from: _____

Address: _____

Phone: _____Fax_____

_____I authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human
(Initial)Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

_____I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human
(Initial)Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Specifically describe information to be released_____

This authorization will expire **90 DAYS** from the date below.

When my information is used pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA privacy rule. I have the right to revoke this authorization in writing except to the extent that Infectious Disease Specialists of Atlanta, P. C. has acted in reliance upon this authorization. I further understand that there may be a charge for copies according to the State of Georgia fee schedule Pursuant to the Official Code of Georgia Annotated (O.C.G.A.) 31-33-3. My written revocation must be submitted to Infectious Disease Specialists of Atlanta, P.C. Privacy officer at:

2665 North Decatur Road
Suite 330
Decatur, GA 30033

Signed by: _____
(Signature of Patient or Legal Guardian) (Relationship)

Print Name: _____
(Date of Birth)

Address: _____

Phone: _____

Date: _____

Please fill this form out in its entirety.

Website address: www.idsatlanta.com