1900 Riverside Parkway
Lawrenceville, GA 30043
: 770-237-3475
:1-877-JOINT-50
: 770-237-3756
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Sports Medicine South
Atlanta's Orthopaedic & Sports Medicine Specialists

Authorization to Release Protected Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Patient Name: _____ **DOB:** _____

Use of disclosure:

I hereby authorize Sports Medicine South, LLC to disclose the information listed below to the following personnel, organization, or entity:

please provide as much information as possible

Name of Person and/or Organization:	
Fax Number:	E-Mail Address:

Authorization Applies to:

[ ] All health information pertaining to any medical history, mental or physical condition and treatment received, **OR**

[ ] Only the following records for a specific Date of Service range: _____ to _____, **OR**

[ ] Records pertaining to a specific type or treatment, injury, and/or procedure:
(please list details) _____
_____

Purpose for Disclosure:

[ ] Patient Request **[ ]** Further Medical Care **[ ]** Insurance **[ ]** Other: _____

This Authorization Will Expire On: (specify a date or event) _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Sports medicine South, LLC has acted in reliance upon this authorization. My written revocation must be submitted to Sports Medicine South, LLC's privacy officer at 1900 Riverside Parkway, Lawrenceville, GA 30043

_____ _____
Signature of Patient/Guardian Print Name

_____ _____ _____
Date Phone Number Relationship to Patient (If a Minor)