Davis Bozeman LAW

AUTHORIZATION FOR RELEASE OF INFORMATION

I, The Undersigned, Authorize:

Name of Facility: _____

Address: _____

City: _____

State, Zip: _____

To Release Information from the Records Of:

Patient Name: _____

Patient Date of Birth: _____

Patient Social Security Number: _____

To Release the Following Information for the Following Dates:

_____

_____

Information Authorized to Be Released:

_X_ Any and All Medical Records and Films

_X_ Any and All Billing Information

_X_ Any and All Records From Other Providers

__ Other: _____

Information May Be Released To:

Name of Law Firm: The Davis Bozeman Law Firm, PC

Address: 4153-C Flat Shoals Parkway, Suite 332

City, State, Zip: Decatur, Georgia 30034

Telephone: (404) 244-2004

Purpose of Disclosure: Litigation

Understandings:

1. I understand that this consent may be revoked in writing at any time. With the exception and to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above-named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed three (3) years from the date of signing. To initiate revocation of this authorization, direct all correspondence to the "Specific Requestor" above.

2. I understand that this consent is to include disclosure of: **(PLEASE INITIAL EACH)**

   _____ Alcohol and/or Drug Abuse Records

   _____ Psychiatric Records

   _____ Sexually Transmitted Disease Information

   _____ HIV/AIDS Information

3. **I understand that a photocopy of this authorization is to be considered valid as the original.**

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact The Davis Bozeman Law Firm, PC.

SIGNATURE: _____
Patient or Personal/Legal Representative (Next-of-Kin or Legal Guardian to sign only if patient is a Minor, Legally Incompetent or Deceased)

PRINT NAME: _____ DATE: _____

Relationship to Patient or Personal/Legal Representative Signing: _____