## The Longstreet Clinic, P. C. AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION Return Fax to 770-297-5634

Home Address, City, State, Zip  1 hereby authorize the use/disclosure of my protected health information as described below.  1. The information that may be used or disclosed is the following:	atient Name	(Please Print)	Date of Birth	IDX #	
1. The information that may be used or disclosed is the following: All of my protected health information including privileged information (HIV/AIDS, psychological, drug/alcohol information) All of my protected health information with the exception of privileged information Other (describe in a specific and meaningful fashion):  2. The information will be used or disclosed for the following purposes: As requested by meOther (describe):  3. Persons/organizations authorized to use or disclose (release) the information (check one): The Longstreet Clinic (identity physician)Other (identify and give address) Street Address:City:State:Zip:  Telephone #:Fax #:  4. Persons/organizations authorized to receive the information:  Street Address:City:State:Zip:  Telephone #:Fax#:  5. This authorization will expire (check one): 90 days from the date of signing When I revoke this authorization in writing as described below Other expiration event that relates to you or the purpose of the use/disclosure: Other (specify date)  I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer protected by federal privacy regulations. I understand that I may revoke this authorization in writing at any time by sending the revocation.  TLC Medical Records Department, except to the extent that action has been taken in reliance on this authorization Aside from this 1 under that upon expiration of the authorization, no further use or disclosure of the information may be made. It understand that I may be declined treatment if I refuse to sign this authorization only when: (1) the treatment is related to a research project and this authorization is for the	Home Address, City, State, Zip		Pl	nysician	
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(A copy of this signed form will be provided to the individual and/or the individual's legal representative)

Revised 1/13/04