# NORTH ATLANTA ENDOCRINOLOGY AND DIABETES, P.C.

771 Old Norcross Road, Suite 200 Lawrenceville, GA 30046
Fax number: 770-962-7868 Phone number: 770-339-1387

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

**Patient Name:** _____ **Date of Birth:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Telephone Number:** _____ **Fax Number:** _____

**Email Address:** _____

❑ I hereby authorize North Atlanta Endocrinology and Diabetes, P.C to make the disclosure of my individually identifiable health information as described below to:

**Doctor or Patient:** _____

**The following patient information is to be disclosed:** (Please check box for each item)

- ❑ Physician/Office Notes
- ❑ Lab Results
- ❑ X-Ray Reports
- ❑ Ultrasound Reports
- ❑ Pathology Reports
- ❑ MRI Scans/CT Scans
- ❑ Bone Density Reports
- ❑ Other: _____

❑ I hereby authorize: (Doctor or Patient) _____
to make the disclosure of my individually identifiable health information as described above to North Atlanta Endocrinology and Diabetes, P.C:

**Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for drug and alcohol abuse.

**Redisciosure:** I understand that any disclosure of information carries with it the potential for redisciosure and that the information then may not be protected by federal confidentiality rules.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

**Other Rights:**

a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
(If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)

**Signature of patient or legal representative:** _____ **Date:** _____

**If signed by legal representative, relationship to patient:** _____

# NORTH ATLANTA ENDOCRINOLOGY AND DIABETES, P.C.

## REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice of Privacy Practices of North Atlanta Endocrinology and Diabetes, P.C. provided to our patients includes information about how we collect and use the protected health information of our patients. This notice also contains a section on Patient Rights that describes our patient's rights under the current privacy law. These laws confirm that patients have the right to access, inspect, and copy the protected health care information used to make decisions about them.

This form is to request access to your records, however, please keep in mind that any questions you may have about medical records created by another practice or health care provider must be directed to that provider. In providing access to these records:

1. We will only include information used to make decisions about the patient
2. We may limit access to information generated only by this Practice
3. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information
4. We may also provide a summary of the requested information, if you are agreeable. This may be preferred when there is a large volume of chart pages or to provide a layman's description of complex medical data

Our Privacy Officer will evaluate your request and notify you of our decision within fifteen (15) days of this request. If the request is approved, we will provide the information within thirty (30) days. In some circumstances an extension of up to sixty (60) days may be necessary, for example, if patient is inactive or the chart is many years old.

Reasonable costs will be charged for the copying of records. The first time we copy your record, there is no charge. Any requests thereafter have a fee. We will charge you $25.88 to cover search, retrieval and administrative costs. If we have to certify a record the cost will be $9.70. In addition, the per page charge is as follows: Pages 1-20 are .97 per page, pages 21-100 are .83 a page and pages over 100 are .66 per page. Costs will be submitted to the patient upon approval of the Request.

Signature of patient or legal representative: _____ Date: _____

If signed by legal representative, relationship to patient: _____