Authorization for Release of Information

I hereby authorize the use or disclosure of my protected health information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the person or organization authorized to receive my private health information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Client name: _____ DOB:_____

Persons/organizations authorized to release your PHI:

Emory Healthcare/Emory clinic

Persons/organizations authorized to release your PHI:

Tamara Weiss, M.D., LLC

Specific description of PHI to be released (including date(s)): Entire medical and mental health record including substance use information and psychotherapy notes. May include information on legal history and sexually transmitted diseases including HIV. Also to include labs, imaging, and list of medications

Specific restrictions you want placed on release of your PHI: NONE

I understand that this authorization will expire on _____, or in 1 Year. I understand that I may revoke this authorization at any time by notifying Dr. Weiss in writing, but my revocation will not affect any releases made or other actions taken before the date of my revocation.

Reason for Disclosure

____For Own Use ____For Use by another Provider ____Documentation for Medical Leave

_X_ Other - Transfer of care.

I understand that I am not required to sign this authorization form. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I will receive a copy of this form after I sign it.

_____ _____

Signature of Client or Personal Representative Date

If not the client, please print name and state legal authority to sign for client below.

_____

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