Dr. Claire L. Visitacion
323 Resource Parkway
Winder, GA 30680
T- (678)975-7471/ F-(678)975-7055
www.bethlehemdoc.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____ DOB: _____/_____/_____

The person named above is or has been a patient of:

Name of Facility/Office: _____ Phone Number: (_____)_____

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

The person named above authorizes (Name of person, provider, or facility)_____ to

( ) Request health information from
( ) Discuss health information with
( ) Send health information to
( ) Discuss health information with

The person named above authorizes information to be requested or released by representatives of:

Name of Facility/Office: _____ Phone Number: (_____)_____

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

Starting Date of Service(s): _____ Ending Date of Service(s): _____

( ) Complete Medical Records
( ) History & Physical
( ) Discharge Summary
( ) Operative Report
( ) Consultation Reports
( ) X-ray/Imaging Reports
( ) Progress Notes
( ) Laboratory Test Results
( ) Immunization Records
( ) Other _____

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by the federal privacy laws.

I understand that this authorization may be revoked at any time. This must be in writing to the office. This would not apply to information that has already been released prior to my written revocation. I also understand that I may refuse this authorization.

Patient/Guarantor Name (Printed): _____ Date: _____

Patient/Guarantor Signature: _____