GNR PUBLIC HEALTH

GNR Health District
TB/PREVENTIVE HEALTH CLINIC
Lynn Paxton, M.D., MPH, District Health Director

455 Grayson Hwy., Ste 400
Lawrenceville, GA 30046
678-442-6880 (P)
866-399-7601 (F)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name		
Patient Address		
City	**State**	**Zip**
Patient #:	**Date of Birth:**	
Identifier (SSN, License or Other):		

I hereby authorize this practice to make uses and disclosure of my Protected Health Information (PHI) (information about me in my medical records and/or financial records) as indicated below.

To obtain from:

(Name of Person or Agency Holding the Information)

(Address)

The information may be disclosed to: **(Name/ Address of Person or Agency Requesting Information)**

Name: Lawrenceville Health Center	**FAX: 866-399-7601**
Address: 455 Grayson Hwy., Ste 300	
City: Lawrenceville **State: GA**	**Zip: 30046**

Description of information to be disclosed:

For the purpose of:

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
- The practice will not condition treatment or payment based on my signing this authorization
- I am signing this authorization freely
- The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use and have received a copy of the authorization

All information I authorize to be released from this agency will be held strictly confidential. I understand that this authorization will remain in effect for:

- ☐ Ninety (90) days, unless I specify an earlier expiration date here:_____.
  Date
- ☐ One (1) year from the date of signature.
- ☐ The period necessary to complete all transactions on accounts related to services provided to me.

Patient Signature:	**Date:**
Signature of Patient's Representative:	**Date:**
Signature of Witness:	**Date:**
Title or Relationship to Patient:	**Expiration Date:**