GNR PUBLIC HEALTH

PREVENTIVE HEALTH CLINIC
455 Grayson Highway, Suite 400
Lawrenceville, GA 30046
678.442.6880
866.399.7601
www.gnrhealth.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:		
Date of Birth:	**Patient #:**	
Patient Address:		
City:	**State:**	**ZIP Code:**
Identifier (SSN, license, 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 of person or agency holding the information

The information may be disclosed to (name/agency requesting information):

Name: Preventive Health Clinic **Fax #:** (866) 399-7601
Address: 455 Grayson Highway, Suite 400
City: Lawrenceville **State:** Georgia **ZIP Code:** 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:

☐ 90 days, unless I specify an earlier expiration date here: _____
☐ 12 months from the date of signature.
☐ The period necessary to complete all transactions on accounts related to services provided to me.

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