Apollo Family Medicine
Dr. Asmita Joshi, M.D.
3990 Old Milton Pkwy, Ste. 200
Alpharetta, GA 30005
TEL#: (470) 875-1560
FAX#: (470) 781-2710

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I. I hereby authorize to use and/or disclose my protected health information at **Apollo Family Medicine**, as described below to ____
[Spouse or family member Name]

II. Authorization for Release of Information

A.

□ Covering the period of health care from _____________ to ____________ **OR**

□ All past, present and future periods

AND

B.

□ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

□ I hereby **authorize the release of my complete health record with the exception of the following information:**

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): ___________________________________

Apollo Family Medicine
Dr. Asmita Joshi, M.D.
3990 Old Milton Pkwy, Ste. 200
Alpharetta, GA 30005
TEL#: (470) 875-1560
FAX#: (470) 781-2710

CONTINUED

III. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

IV. This authorization shall be in force and effect until________________, at which time this authorization expires.

V. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

VI. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

VII. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ________________
Signature of Patient or Legally Authorized Representative Date

____
Name of Patient or Legally Authorized Representative

____
Relationship to Patient