Health Insurance Portability & Accountability Act (HIPAA)

Patient Name: ____ D.O.B: ________________________

Phone: ______________________________________

I have agreed to let certain individuals to participate in discussions and decisions related to my medical care. Therefore, I hereby give permission to the physicians of Atlanta Area Orthopedic & Imaging, LLC and their staff to disclose my personal medical information to the following individual(s):

Name: ____ Relationship to patient__________________________

Name: ____ Relationship to patient__________________________

Name: ____ Relationship to patient__________________________

Conditions for Disclosure (Check the item(s) that apply):

O The practice may disclose my personal health information to the individual(s) above **ONLY** in my presence.

O The practice may disclose my medical information to the individual(s) above in discussions while in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

O Other conditions of Disclosure____

O The practice may **not** disclose my medical or personal health information to anyone in my presence or when I am not physically present.

I understand that this consent may be revoked by me at any time by written notice to the practice.

I understand that a copy of the Health Insurance Portability & Accountability Act (HIPAA) is available to me upon my request.

Patient Signature: ____ **Date: ____________________**

Witness Signature: ____ **Date: ____________________**

Phone: 770-277-9222 **Fax: 770-817-0186**

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