PATIENT AUTHORIZATION FORM

H. William Martin, Jr., M.D.
5605 Glenridge Drive, Suite 600
One Premier Plaza
Atlanta, Georgia 30342
TEL: 404-252-3001 FAX: 404-257-0299
bmartin247@gmail.com
martinoffice.com

I hereby authorize *H. William Martin, Jr., M.D.* to release/obtain (please circle one) the specific information described below, for the following purposes:

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Authorized person requesting information____

Release/Obtain information to/from:

Name____

Address____

Phone___________________________________Fax___________________________________

This authorization shall remain in effect from the date signed below until______________

I understand that:

- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information released or obtained pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.

Patient Name____

Signature____

Relationship to patient__________________________________Date___________________