NORTH GEORGIA
Allergy Asthma
& Immunology LLC

Anita Shvarts, M.D.
85 Seasons Lane
Hiawassee, GA 30546
[p] 855.656.6673
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Authorization For Use and Disclosure of Protected Health Information

Patient Name: _____Date of Birth: _____

Address: _____

_____

Phone : _____

By signing this authorization, I authorize North Georgia Allergy Asthma & Immunology LLC to use and/or disclose certain protected health information (PHI) about me to

_____

Name of entity to receive this information.

Send The Health Information To:

Name**:**_____

Address: _____

_____

Phone**:** _____ Fax: _____

Who is Making the Request?

The name of the person (or entity) authorized to make this request: _____

Relationship to patient or the person (entity) making the request: _____

What Information is Requested? This authorization permits North Georgia Allergy Asthma & Immunology LLC to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): _____

Why This Information Is Requested? The information will be used or disclosed for the following purpose: _____. If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

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The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI

Expiration Date of This Authorization: _____ Such date cannot be greater than 90 days from the date of the request. If no date is given the authorization will expire 90 days after the signature date below.

I understand that I do not have to sign this authorization in order to receive treatment from North Georgia Allergy Asthma & Immunology LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at the practice named in the letter head above.

Date: _____

_____
Print name

_____ _____
Signature of Patient or Personal Representative Relationship to Patient