Johns Creek Surgery, PC

I hereby authorize the release of my health information as listed below.

Patient name:_____ **Date of Birth:**_____

Address _____ **Telephone:** _____

Provider or facility authorized to release information:
Johns Creek Surgery, P.C., 6920 Johns Creek Pkwy, Ste 340 Suwanee, Ga 30024 P: 770-232-2911 F: 770-232-2996

Person or entity authorized to receive information: _____

Address _____

Phone Number:_____ **Fax Number:**_____

Description of information:
☐ *Entire Record ☐ Other _____ ☐ Specific Dates of Service _____

*Medical Records to be released will only include records regarding my medical care by Johns Creek Surgery, PC, and **will not include** records from other providers. Any medical records provided to Johns Creek Surgery, PC by other entities will not be forwarded, and requests for those records must be made to originating provider.

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1. This authorization will expire: ☐ Date:_____ ☐ Event:_____ ☐ One year
   Unless otherwise specified, this authorization will expire 90 days after the date of this request.

2. **I understand** that I may revoke this authorization at any time by notifying the Facility's Privacy Officer in writing of my revocation. I understand that revocation will not have any affect on actions the Practice took before they received the revocation.
3. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim.
4. **I understand** that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.
5. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosers, as allowed by HIPAA and other federal privacy rules.
6. **I understand** that the information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, **may be subject to re-disclosure by the recipient and no longer protected** by federal privacy regulations or other applicable state and federal laws
7. This facility, its employees, officers, and physicians are hereby **released from any legal responsibility or liability** for disclosure of the above information to the extent indicated and authorized herein**.** This authorization is voluntary. **I understand** that my treatment or payment for services will not be affected if I do not sign this authorization.

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative:_____ **Relationship to the patient:** _____