Favor Family Medical Practice

HIPAA Privacy Authorization Release 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)
Patient Name: _____MRN: _____
Date of Birth: ___/___/___ E-mail Address: _____
I_____, hereby authorize and request Favor **Family Medical Practice of 103 Mountain Brook Dr Unit 100, Canton Ga 30115** to release my health information (PHI) to:

☐ **Lab Results/Radiology Results** ☐ **Medical History**

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

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. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

Signature of Patient Date:
