Albany Area Primary Health Care, Inc.

204 N. Westover Blvd., Albany, GA 31707-2983
Phone (229) 888-6559, Fax (229) 436-4107

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ Date of Birth: __________________________

Patient Address: ____

By signing below, you hereby authorize Albany Area Primary Health Care, Inc. and all affiliated clinics to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment, and health care operations. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. A copy of the Notice of Privacy Practices is provided to you by us prior to you signing this Authorization. The terms of this notice may change from time to time; you may request a current copy of the Notice of Privacy Practices at any time.

Your "protected health information" means all health information and medical records, including demographic information, collected from you and created or received by your physician, another health care provider, a health plan, your employer or a health care claims clearinghouse. Additionally, this authorization includes release of all medical records. You may revoke this authorization and consent in writing at any time except to the extent that AAPHC has already taken action in reliance upon this authorization. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information identifies you.

If someone calls or visits and asks about you, can we acknowledge that you are here? ☐ Yes ☐ No

There are multiple ways for our office to communicate with you. Your preference will be discussed during the registration process and this will be documented within your electronic health record. *We utilize the following methods to contact patients: Telephone/ Messaging, Email, Patient Portal, and/or Written documentation.*

I hereby give permission to the person(s) listed below to authorize treatment, attend examinations, and to receive information about the care of the patient listed at the top of this form. This includes but is not limited to: information about the patient's general medical condition and diagnosis (including treatment and payment options), access to medical records (protected health information), prescription pick-up, and the ability to set appointments.

1. ____ Relationship to patient: __________________________
2. ____ Relationship to patient: __________________________
3. ____ Relationship to patient: __________________________

____ ___________________________________

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am their: ___________________