The Kaufmann Clinic, Inc.

Crawford Long Medical Office Tower, 550 Peachtree St., Suite 1700, Atlanta, GA 30308
2001 Professional Way, Suite 220, Woodstock , GA 30188

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize **THE KAUFMANN CLINIC, INC.** to use and disclose a copy of the specific health and medical information described below regarding

_____

(Print Name of Patient)

consisting of : (describe information to be used/disclosed here)

Name of Recipient_____

Or Class of recipients_____

For the purpose of: (describe purpose of disclosure here)

Authorization to Use and Disclose Health Information (continued)

If we are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization;
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on the Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

By:_____ Date:_____
(Patient)

Or By:_____ Date:_____
(Patient's Representative)

Description of Representative's Authority_____

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