Atlanta Arthritis Center, P.C.

Phone: 678-867-0000 Fax: 678-867-0003

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

Atlanta Arthritis Center, P.C. will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Atlanta Arthritis Center, P.C. may use or disclose medical records, treatment notes, test results or any other part of the medical chart for the purpose of medical treatment, processing or collecting financial reimbursements.

By signing this authorization you agree that Atlanta Arthritis Center, P.C. or its Business Associates may disclose your personal health care information to other treating physician's or insurance companies or other collection agencies if needed.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Atlanta Arthritis Center, P.C. HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Atlanta Arthritis Center, P.C. has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available at the Atlanta Arthritis Center P.C. office or by sending a written request with return address to 1305 Hembree Rd. Suite 101, Roswell, GA 30076.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Atlanta Arthritis Center, P.C. for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or (d) six years from the date this authorization was executed.

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By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA. This form also allows Atlanta Arthritis Center, P.C. to call my phone number on record for reminder of appointments, test results or financial information.

Atlanta Arthritis Center, P.C. will provide ______________________________ [name of patient] with a copy of this signed authorization.

Acknowledged and agreed to by:

PATIENT:

By_________________________________ ______________________________________
Print Name__________________________ Date

Address:_____________________________
____
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or, ON BEHALF OF PATIENT

By_________________________________ ______________________________________
Print Name__________________________ Date
As_________________________________

Address:_____________________________
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