PREMIER SOUTH MEDICAL GROUP, PC.
3890 Redwine Road, Suite 200
Atlanta, Georgia 30331

Office: (404) 344-6000
Fax: (404) 344-6575

Effective Date of this Notice: 4/13/2003

Patient Authorization for Use and Disclosure of Protected Health Information

Patient's Name: _____
Patient's D.O.B: _____
Patient's S.S.N.: _____

By signing this authorization, I authorize _____ to use and
Name of Doctor or Facility
disclose certain protected health information about me to Premier South Medical Group, P.C.

This authorization permits the above named Doctor or Facility to disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of details to be released, origin of information, etc.)

_____
The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.
Expiration Date

I do not have to sign this authorization in order to receive treatment from Premier South Medical Group, P.C. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. **Please send Records to:**

Premier South Medical Group, P.C.
3890 Redwine Road, Suite 200
Atlanta, Georgia 30331

Phone: (404)-344-6000
Fax (404)-344-6575

Signed by: _____ _____
Signature of Patient or Legal Guardian **Date**

_____
Relationship to Patient