ROZIN Internal Medicine
Spencer I. Rozin, MD FACP
721 Wellness Way, Suite 220
Lawrenceville, GA 30046
Office (770) 709-0900 **Fax (770) 709-7444**

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THE PRACTICE

By signing this authorization, I authorize ______________________________ to use and/or disclose certain protected health information (PHI) about me to ROZIN INTERNAL MEDICINE. This authorization permits _________________________ to use and/or disclose the following individually identifiable health information about me: (Specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.)

____
____
____

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

Medical Management by PCP Other: _______________________________

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of information. This authorization will expire on ______________________.

Expiration Date or Defined Event

The Practice will will not receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I DO NOT HAVE TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE TREATMENT FROM ROZIN INTERNAL MEDICINE. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice previously acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Office at: 721 Wellness Way, Suite 220, Lawrenceville, GA 30046.

Signed by: ________________________________ ____________ ____________
Signature of Patient or Legal Guardian Date of Birth SSN

________________________________ ____________
Print Patient's Name Date

____
Print Legal Representative's Name