PIEDMONT COLORECTAL ASSOCIATES, P.C.

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PATIENT AUTHORIZATION FOR PRACTICE RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Piedmont Colorectal Associates, P.C. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Piedmont Colorectal Associates, P.C. to use or disclose to

_____
Person or Entity to receive the information

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

_____

_____

This authorization will expire on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may 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 Piedmont Colorectal Associates, P.C. has acted in reliance upon this authorization. My written revocation must be submitted to Piedmont Colorectal Associates, P.C.'s Privacy Officer at 35 Collier Road, N.W., Suite 475, Atlanta, GA 30309.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

THIS FORM SHOULD BE FILLED OUT IF YOU HAVE SOMEONE WHO WILL BE CALLING TO SCHEDULE APPOINTMENTS FOR YOU, DISCUSS RESULTS, OTHER TREATMENT RELATED QUESTIONS OR ACCOUNT QUESTIONS ON YOUR BEHALF.