

**PIEDMONT COLORECTAL ASSOCIATES, P.C.**  
**35 COLLIER ROAD, N.W., SUITE 475**  
**ATLANTA, GEORGIA 30309**  
**404-351-7900 404-351-7901**  
[www.piedmontcolorectal.com](http://www.piedmontcolorectal.com)

**PATIENT AUTHORIZATION FOR PRACTICE RELEASE OF 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 re-disclosure 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

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian