MCINTOSH CLINIC, P.C. / Privia Medical Group
119 West Hill Street
Thomasville, GA 31792
(229) 225-1900 or (800) 782-8507
Fax: (229) 225-3461

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize McIntosh Clinic, P.C. to use and/or disclose certain protected health information (PHI) about me to_____.

The PHI that will be used and/or disclosed includes: _____

_____

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

___ Continued Care
___ Insurance Company Request
___ Personal Use
___ Other:_____

The purpose is provided so that I can make an informed decision whether to allow release of the information.

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that McIntosh Clinic will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, First Physicians group will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

_____ _____
Patient/Legal Guardian Signature Relationship to Patient

_____ _____ _____
Print Name Patient DOB Pt. Chart #

_____
Date

Rev. 10/2016:mg