

HIPAA AUTHORIZATION FORM

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:
2. The following person or class of persons may receive disclosure of protected health information about me:

A. Spencer McManes, Jr., P.C.
Attorney at Law
1015 Powers Place
Alpharetta, Georgia 30009-8356

3. The specific information that should be disclosed is:

Medical records, medical billings, narratives, copies of prescriptions, copies of medical referrals.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
6. This authorization expires on _____, 200____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: my workers' compensation hearing.

This form must be fully completed before signing.

Signature of Individual

Date of Signature

Date of Birth

Social Security No.