ANDRO GIORGADZE , MD

696 Concord Rd SE
Smyrna, GA 30082

ph: 678 701 7725
fax: 404 855 3924

email: androg@gmail.com
web: webpsychiatry.net

HIPAA Privacy Authorization Form

I authorize _____(name of your provider)

phone # : _____ Fax # : _____

to use and disclose the protected health information described below to

to Andro Giorgadze, MD Phone: 678-701-7725 Fax # 404-855-3924

This authorization for release of information covers the period of healthcare from:

a. _____ to _____

or

b. ☐ all past, present and future periods

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

or

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol / drug abuse treatment

☐ Other (please specify) _____

This medical information may be used by the person I authorize to receive this infomration for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until _____ (date or event), at which time the authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date