FAMILY HEALTH INFORMATION ACCESS FORM

_____
Date

_____

Patient Name ID#

I, _____, authorize Dalton Family Practice to release any of my individual identifiable health information to:

_____

Name Relationship Phone

_____

Name Relationship Phone

_____

Name Relationship Phone

I understand, if the party/parties authorized to receive this information are not a health plan or a health care provider, the released information may be redisclosed and may no longer be protected by federal privacy regulations.

I understand this authorization will remain in effect until I revoke it in writing to Dalton Family Practice, 1114 Professional Blvd, Dalton, GA 30720. Attn: Privacy Officer.

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Signature of Patient or Patient's Legal Representative