PACT Atlanta, LLC

465 Winn Way, Suite 221
Decatur, GA 30030
Phone: 404-292-3810 Fax: 404-292-3848

Patient Authorization for Bi-Lateral Release of information

Please Check One: ⬭ Incoming ⬭ Outgoing ⬭ Bi-lateral

By signing this authorization, I authorize the bi-lateral release of the following information between PACT Atlanta, LLC and:

Name: _____

Address: _____

Phone: _____ Fax: _____

This authorization permits PACT Atlanta, LLC and the party listed above to use and/or disclose the following individually identifiable health information to me (specifically describe the information to be used or disclosed, such as date(s) of service, types of service, level of detail to be released, origin of information, etc.):

_____

_____

_____

This information will be used or disclosed for the following purpose: _____

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

I do not have to sign this authorization to receive treatment from PACT Atlanta. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure 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 the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at PACT Atlanta, LLC.

Signature: _____Date: _____

Client's Name (Please Print): _____