Janice H. Loeffler. MD PC
3014 N Patterson St
Valdosta. GA 31602
Phone: 229-242-0194 Fax: 229-242-1785

Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize

_____

(Name of organization, address/phone/fax #) to use and/or disclose certain protected health information (PHI) as noted below **TO** Janice H. Loeffler, M.D., P,C.

This authorization permits _____ _____ (ORGANIZATION) to use and/or disclose the following individually identifiable health information about _____(name of child and DOB) which includes the complete medical records, including birth history and metabolic screen if child is under 2 years of age, labs/x rays, diagnostic tests, immunization records and consultant notes or for the following specific dates: _____

I understand that any part of my protected health information that is categorized as "psychotherapy notes" will **not** be included under this authorization.

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

_____ _____

If the above is left blank, purpose shall be "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 _____

{Expiration Date or Defined Event}

I do not have to sign this authorization in order to receive treatment from Janice H. Loeffler, MD PC. 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 re-disclosure 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:

Janice H Loeffler, MD PC
Address: 3014 N Patterson St, Valdosta, GA 31602
Telephone Number: 229-242-0194
Attn: Privacy Officer

_____

Printed Name of Patient or Legal Guardian and date

_____

Signature of Patient or Legal Guardian and date