

AUTHORIZATION TO PROVIDE INFORMATION

I authorize the release of any medical information, including history, treatment, diagnosis, and prognosis and any information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care provided, health related utilization review or quality assurance activities.

I authorize any medical information including history, treatment, diagnosis, and prognosis to be released to:

The Physicians' Pain & Rehabilitation Specialists of Georgia, P.C.
790 Church Street
Suite 550
Marietta, GA 30060
(770) 419-9902
FAX (770) 419-7457

I understand that pursuant to the Health Insurance Portability and Accountability Act (HIPAA) this protected health information is being used by The Physicians' for the purpose of providing treatment, and the business operations and billing that go along with this treatment.

Patient Name:	Date of Birth:
Signature of Patient:	Date:

I understand that this office routinely utilizes **e-mail** rather than a fax machine in order to conduct its operations and communicate with my referring physician and case manager. I understand that this office feels that there is increased security with the use of **e-mail**, as they are then better able to assure that the information is going directly and exclusively to the correct individual's e-mail address instead of a general fax machine, which may be seen by a number of people. I understand that the information being sent via e-mail from this office is going out in an encrypted format in order to provide further protection. I understand that this office will use e-mail in the following instances:

- Providing a copy of my treatment to my referring physician
- Providing a copy of my treatment to my case manager or case adjuster
- Answering questions for me that I have sent to the office via e-mail

I understand that I can request that the office **not** utilize e-mail for my information by checking the box below and signing. I understand that the office will not condition my treatment on whether or not I provide authorization for the use of e-mail.

Check the box if you would **not** like to utilize email communications:

Patient Signature: _____