Authorization for Release of Information

Many of our patients allow family members and significant others access to personal health information. Under the requirements of HIPAA, (**Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers**) we are not allowed to share this information to anyone without the patient's written consent. If you wish to have your medical or billing information released you must sign this form. Signing this form will only give information to the individuals indicated below.

I authorize Piedmont Medical Associates to release my medical and/or billing information to the following individual(s): **This information being released includes refill request, picking up of prescriptions, scheduling appointments, discussing medical records including lab results, and discussing financial matters.**

Name of Relative	Relationship to Patient	Phone number of Relative

I ______________________________(print) understand I have the right to revoke this authorization at any time. You have the right to revoke this consent in writing. I understand that the information disclosed to any of the individuals listed above is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Name: ____________________________ PMA Staff: __________________________

Patient Signature: ____________________________ Date: ____________________________