AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____(*name of patient*), DOB: _____(*date of birth)* hereby voluntarily authorize the use and disclosure of protected health information of _____ (*name of patient*) as follows:

1. Disclosure of Information. The information may be disclosed by (*name and address of providers*):

Name/Address/Phone #	Name/Address/Phone #	Name/Address/Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If you need more columns, please attach a signed second copy of the form with the additional names)

And is to be shared between the providers listed above and between:

All providers associated with The SouthEast Eosinophilic Disease Center of Atlanta, Inc. / The SEED Center of Atlanta, Inc. and all providers associated with my care.

993-D Johnson Ferry Road
Suite 440
Atlanta, GA 30342
Attention: Sheryn Cohen

2. Purpose of Disclosure:

☐ Sharing of all Medical Records
☐ _____

3. Information to be Disclosed. The information to be disclosed from my health record: (*check appropriate box(es)*):

☐ Only information related to (*specify*):
_____
_____

☐ Only the period of events from _____to_____
_____

☐ Other (*specify*):
_____
_____

☐ Entire Record

☐ I understand that I may revoke this authorization in writing submitted at any time to The SEED Center of Atlanta, Inc. or any other provider listed above, except to the extent that any action has been taken in reliance on this authorization. I hereby consent and authorize the release of copies of my medical records from other practices and practitioners, hospitals, and/or clinics which are part of my medical records. I agree that a copy of this release by fax or electronic transmission shall be valid as the original release.

_____ Date:_____
Signature of Patient

_____
Patient's Name

_____
Relationship to Patient