Matthew W. Norman, M.D., LLC

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: _____ **Birth date:** _____

I request and authorize _____ to release the health care information described below to / from :

Name: Matthew W. Norman, M.D.

Address: 4401 Northside Parkway, NW, Ste 245

City, State: Atlanta, GA **Zip code:** 30327

This request and authorization applies to only the following protected health information:

ALL

during the following time period or dates: ALL

Purpose(s) of this use/disclosure: X **At the request of the individual** __ **Other:** _____

Authorization expires on ____ / _____ /_____(or one year from date of signing).

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Dr. Norman.
I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

_____ _____

Signature (patient or authorized representative) **Date:**

Relationship/authority (if signed by authorized representative): _____
I have received a copy of this signed authorization: (please initial) __ yes _X_ no

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R.Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.