2359 Windy Hill Rd STE 210
Marietta, GA 30067
404-980-9800

MedFit

HEALTH CARE AUTHORIZATION FORM

Patient's Name:_____
Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES MEDFIT OF GEORGIA LLC TO USE AND OR DISCLOSE PROTECTED HEALTH IMFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- I give permission to Medfit Of Georgia LLC, to use my address, phone number, and clinical records to contact me with appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information. I also give permission allowing my name to be posted on a referral board or my picture to be posted on message board for office related events. In the future should I write a testimonial regarding my treatment in this office, I give permission for it to be posted.
- I grant permission for Medfit Of Georgia LLC to share my health records and lab results with N.F.C and/or Mr. David Oblas as necessary.
-
- If Medfit Of Georgia LLC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail, or with the individual who answers the telephone.
- I grant permission for Medfit Of Georgia LLC to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may over hear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Medfit Of Georgia LLC, permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a wrtitten notice to the Privacy Official of Medfit Of Georgia LLC.The written notice must contain the following information:

Your full name and date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Medfit Of Georgia LLC, for its own use/disclosure of Protected Health Information. (Minimum standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Medfit Of Georgia LLC will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

Print Name:_____ **Patient Signature:**_____
Date_____