



**William H. Megdal, M.D.**  
**Benjamin E. McCurdy, M.D.**  
855 King Avenue  
Athens, Georgia 30606  
(706) 425-2400 Phone  
(706) 425-2410 Fax

## Authorization for Disclosure of Protected Health Information (Medical Records Release)

By signing this authorization, I authorize Athens Spine Center (the "Practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed below.

**What PHI may be used or disclosed:**

This Authorization permits the Practice to use or disclose the following PHI:

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*[Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.]*

**Describe the specific purpose(s) for which you authorize the Practice use or disclose this PHI:**

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*[Must include each purpose of the requested Use or Disclosure, but may state: "at the request of the individual" if the individual is initiating the Authorization and does not, or elects not to, provide a statement of the purpose]*

**To whom may the PHI be disclosed:** *[This may be inapplicable if Athens Spine Center is going to use the PHI for its own purposes and not disclose it to a third party.]*

**Entity Name** \_\_\_\_\_  
**Contact Person** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Phone Number** \_\_\_\_\_  
**Fax Number** \_\_\_\_\_

**This authorization will expire on** \_\_\_\_\_

*[Specific expiration date or expiration event must be inserted, but the statement "end of research study" or "none" may be used if the Authorization is for a use or disclosure of PHI for research].*

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (i) to the extent that the Practice has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Administrator at 855 King Avenue, Athens, GA 30606, by sending a written request stating that I wish to revoke this Authorization to the attention of the Practice Administrator.

I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

**FOR RESEARCH RELATED TREATMENT ONLY:** I understand that, in general, that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization, but because this Authorization is being obtained for purposes of research, the Practice may condition research-related treatment on my refusal to sign this Authorization.

**Signed by:** \_\_\_\_\_  
*Signature of Patient or Personal Representative*

**Print Name of Patient or Personal Representative:** \_\_\_\_\_  
*[If Signed by a Personal Representative, please state such person's authority to act for the Individual]*

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