

ATLANTA INFECTIOUS DISEASE SPECIALISTS, P.C.

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**Receipt of Notice of Privacy Practices
Written Acknowledgement Form
Release of Information Authorization**

I, _____, have received a copy of Atlanta Infectious Disease Specialists, P.C.'s Privacy Practices. I am also authorizing the release of my health care information to the following people:

No one is to have access to my records except my physician(s), insurance company, and myself.

I authorize release of information to the following people:

Name: _____ Relationship: _____
Date of Birth: _____ Phone: _____

Name: _____ Relationship: _____
Date of Birth: _____ Phone: _____

Name: _____ Relationship: _____
Date of Birth: _____ Phone: _____

Name: _____ Relationship: _____
Date of Birth: _____ Phone: _____

I am authorizing you to leave messages on my answering machine/voice mail.

I am not authorizing you to leave messages on my answering machine/voice mail.

Other Instructions: _____

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____