Upson Regional Medical Center
801 W. Gordon St. Thomaston, GA 30286
(706) 647-8111

Authorization for Release of Protected Health Information

Date of request: _____ Unit #: _____

1

Patient Name: _____ Birth date: _____

Address: _____
(street) (city) (state) (zip)

Social Security Number: _____ Phone Number: _____

2

I hereby authorize _____ to: _____ obtain my information from OR
_____ release my information to:
_____ Phone #: _____

3

There are no limitations placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health, behavioral or psychiatric treatment.

Revocation Process: I understand that I may, by placing my request in writing to the Privacy Officer, revoke this Authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy. This Authorization will expire three months from the date of my signature or as otherwise specified by date of my signature or as otherwise specified by date, event, or condition as follows:

_____.

Photocopy: I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization, may deny the release of protected health information, if it has reason to believe (1) this authorization has been Altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested.

4 **Information to be Released**

Description:	**Date(s):**	**Description:**	**Date(s):**
[ ] Discharge Summary		[ ] EKG	
[ ] History & Physical		[ ] Echocardiogram	
[ ] Consultation Reports		[ ] ER Information	
[ ] Operative Reports		[ ] Photographs, Videotapes, Digital or Other Images	
[ ] Progress Notes		[ ] Nursing Documentation	
[ ] Laboratory Tests		[ ] Physician Orders	
[ ] Radiology Tests		[ ] Other _____	
[ ] Other_____			
_____			

5

Purpose of disclosure: _____

6

REDISCLOSURE: I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. **SIGNER MUST INITIAL THIS CLAUSE:** _____

Patient Signature _____ **Date:** _____

Signature of Authorized person _____ **Date:** _____

Relationship _____

Contact Person _____ **Extension:** _____

Comments:

MRI.PAT.zcus.fol.m001

MRI.PAT.zcus.fol.m001