Patient Name (please print):		Date of Birth:	MR#:
Street Address:	City:	State:	Zip:
Phone:	Last 4 digits SSN:	E-mail (optional):	

I AUTHORIZE AND REQUEST THE DISCLOSURE OF PROTECTED INFORMATION FROM:

☐ Upson Regional Medical Center
☐ Upson Women's Services, LLC
☐ Orthopedics Sports Medicine & Surgery, LLC
☐ Upson Family Medical Center, LLC
☐ Upson Family Physicians, LLC
☐ Upson Surgical Associates, LLC (includes ENT, Urology, Cardiology and Surgical Associates)

ACTION REQUESTED:

☐ Provide a copy of MY Health Information to: ☐ Obtain copies of My Health Information from:

_____	_____	_____	_____	_____
Name of Person or Entity	Street Address	City	State	Zip

I REQUEST that the COPY of my PHI be PROVIDED VIA: ☐ On Paper ☐ Electronically on CD/DVD

I understand that information provided by a CD/DVD, is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. By choosing to receive my PHI on a CD/DVD., I am acknowledging and accepting this risk.

PURPOSE OF DISCLOSURE: □ Healthcare/Treatment □ Payment/Insurance □ Personal □ Legal □ Other_____

Description of Protected Health Information to be Used or Disclosed:			
Date(s) of Service: **From: _____** **To: _____**	☐ Emergency Room Record ☐ Discharge Summary ☐ History & Physical ☐ Consultation Report(s) ☐ Operative Report(s) ☐ Entire medical record	☐ Pathology Report(s) ☐ Cardiology Reports ☐ Laboratory Test(s) ☐ Radiology Report(s) ☐ Progress Note(s)	☐ Photographs, Videotapes, Digital or Other Images ☐ Other: _____

____ (Initials) I acknowledge, and hereby consent to such, that the released protected health information may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment or related communications, or information related to testing or treatment for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus).

AUTHORIZATION SIGNATURE:

- I understand that I may revoke this Authorization at any time, by placing my request in writing to the Hospital Information Management Department.
- I understand that if the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations and may be re-disclosed.
- I understand that my treatment or payment for treatment cannot be conditioned on the signing of this authorization.
- Unless I revoke this authorization, it will expire 90 days from the date signed, or as specified: _____

_____ _____
Signature of Patient or Legal Authorized Representative **Date**

_____ _____
Print Name of Legal Authorized Representative **Relationship to Patient**