George Regional Health System

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	NAME: DATE OF BIRTH: Address: Day Phone: City: State Zip:
Receiving Party	NAME: Attention to: Address: Day Phone: City: State Zip: **Fax Number (URGENT PATIENT CARE ONLY)**
Information to be Released	Routine Record Sets (indicate date(s) of service _____) ☐ Clinic (office visit lab, radiology, medicines, immunizations) ☐ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) ☐ Billing Records ☐ Copies of Films/Images ☐ Community Pharmacy Charges ☐ Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check these boxes) Only records types checked below ☐ Discharge summary/note ☐ Radiology reports ☐ Emergency record(s) ☐ Medication records ☐ History & physical exam ☐ Rehab records (PT/OT/ST) ☐ Immunization/allergy record ☐ Chemical dependency/ Substance abuse records ☐ Operative report ☐ Laboratory reports ☐ Pathology reports ☐ Consultations ☐ Progress notes/clinic notes ☐ Mental health records ☐ Pathology sides/blocks ☐ Other records specify record type(s) _____ *OPTIONAL Limits - Disclose only records related to* following: *Date(s) of service/:* _____ injury or illness: _____
Release Instructions	Date information is needed: _____ (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING) **Release Method / Format requested: (check one)** ☐ **Paper** ☐ **CD/DVD** ☐ **View my Record** ☐ **Fax (patient care only)** ☐ **Verbal** **Continuing Care Information released by Nursing Station/Department (verbal and paper)** ☐ **yes** ☐ **No**
Purpose of Release	☐ **Continuing care** ☐ **Transfer of care** ☐ **Social security appeal** ☐ **Insurance application *** ☐ **Personal use or review *** ☐ **Social security disability determination *** ☐ **Insurance payment/claim** ☐ **Litigation/legal *** ☐ **Other*** _____ *** Fees maybe charged in accordance with Federal Rule 45 C.F.R. §164.524**

- ○ I understand that this authorization is voluntary. If I do not sign this form, my healthcare and payment for this healthcare will not be affected.
- ○ I understand that once my information is released, it may no longer be protected by Federal privacy regulations.
- ○ I understand that this authorization will automatically expire in thirty (30) days or: _____
- ○ I understand that after I have signed this form, I may change my mind and cancel/revoke the request any time before the information is released by notifying the facilities Medical Record Dept. in writing.

_____ _____ _____
Signature of Patient or Representative Relationship Date

_____ _____
Printed Name of Patient or Representative Witness

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