



Medical Record # _____ Account # _____

Delivery Method: Pick Up Mail Fax ()

Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: _____ S.S.# _____

Date of Birth _____ Patient Phone Number(s): _____

Treatment Dates to Be Released: _____

Type of Visit: Inpatient Outpatient Surgery ER Outpatient Test Therapy Other

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

Spalding Regional Medical Center
601 South 8th Street
Griffin, GA 30224 or

RELEASE INFORMATION TO: (recipient of disclosure)

Name: _____

Address: _____

Apt, Suite or PO #: _____

City, State, and Zip: _____

Phone: _____

Fax: _____

PURPOSE OF THE DISCLOSURE: Insurance Legal Continuing Care Personal Other (specify) _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

- Face Sheet
- Consent Form
- Discharge Summary
- History & Physical
- Operative Reports
- Pathology Reports
- ER Record
- Therapy Records
- Radiology Report*
- Mammogram
- EKG
- Consultations
- Physician Progress Notes
- Physician's Orders
- Other _____

*Does not include x-ray films.
Please see Radiology to obtain films.

SPECIFIC INFORMATION TO NOT BE DISCLOSED: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the HIM Department at Spalding Regional Medical Center. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize Spalding Regional Medical Center and or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release Spalding Regional Medical Center and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable.

PATIENT'S SIGNATURE

DATE

PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN

DATE

WITNESS

DATE