Appling Healthcare

MR#_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Patient Name (print first and last name): _____Date of Birth:_____

Previous Name, if applicable: _____ SSN/*last for only* XXX-XX- _____

Address/Street Number: _____

City, State and Zip Code: _____ Phone:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make disclosure:

Appling Healthcare Health Information Department

Address: **163 E Tollison St, Baxley, GA 31513**

Phone Number: **(912)367-9841 ext. 1279**

3. WHO CAN RECEIVE MY HEALTH INFORMATION:

I authorize the person or facility listed below to receive the health information described in Section 4:

Name of Person or Facility: _____

Address/Street Number:_____

City, State and Zip Code: _____ Phone: _____

Email: _____ Fax: _____

4. WHAT HEALTH INFORMATION CAN BE DISCLOSED:

DATES OF SERVICE: From:_____ To:_____

Please select all of the specific documents that apply to your request:

☐ Radiology Reports	☐ Cardiology/EKG Reports	☐Complete Medical Records
☐ Lab Results	☐ Emergency Room Record	☐Billing Records
☐Operative/Procedure Note	☐ Outpatient Record	☐ Other _____
☐ Pathology Reports	☐ Inpatient Record	

5. THE REASON I WANT TO DISCLOSE MY HEALTH INFORMATION:

Please select the purpose of your request:

☐ Continuity of Care	☐ Personal	☐ Other:_____
☐ Worker's Compensation	☐ Insurance	
☐ Attorney/Legal	☐ Social Service/Disability	

6. HOW INFORMATION SHOULD BE RELEASED:

Please select how you would like to receive your request:

☐ Pick up by ☐patient or ☐name of person picking up:_____

☐ US Mail via the address listed in Section 3.

☐ Email to email address: _____

☐ Fax to number listed above in Section 3.

7. HOW LONG IS THIS AUTHORIZATION VALID? This authorization will expire 6 months from the date it is signed unless I write another date here: _____

8. HOW DO I REVOKE THIS AUTHORIZATION? I understand that I have the right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it. If I am authorizing release of records by Appling, this authorization can be revoked by submitting a written request to the Health Information Services Department of Appling Healthcare at 163 E Tollison St, Baxley, GA 31513. If I am authorizing a non-Appling person or facility to release records, I should contact that person or facility for instructions.

9. WHAT ARE THE FEES FOR RELEASING RECORDS? Federal and state laws allow for reasonable, cost-based fees to be charged for the copying and provision of patient records. If fees apply to my request, I will be responsible for payment of these fees.

10. WILL MY RECORDS REMAIN CONFIDENTIAL AFTER DISCLOSURE? Medical records and information that are disclosed pursuant to this authorization may be further disclosed by the recipient and will no longer be subject to protection under the federal privacy laws and regulations. Any electronic format of my health information may not be encrypted or password protected. I am responsible for taking precautions to protect the data and storing it in a secure manner. I hereby release Appling and its agents and employees from any and all liabilities, responsibilities, damages, and claims that might arise from the release, receipt, and/or re-disclosure of these medical records and the information included therein from a Appling Healthcare.

11. **CAN I REFUSE TO AUTHORIZE DISCLOSURE?** Authorizing the use or disclosure of the information above is voluntary and Appling or my health care provider may not condition treatment upon my signing of this authorization, except in limited circumstances in which (1) such conditioning is permitted for research-related treatment, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers' compensation examination).

12. WAIVER: If the health information I have requested to be disclosed includes any information related to mental health, substance abuse, testing/treatment of infectious diseases (including, without limitation, HIV/AIDS confidential information, venereal disease, tuberculosis, or hepatitis) or genetic testing, I consent to the disclosure of such sensitive health information by Appling or my health care provider and waive any privilege regarding such information for the purpose of releasing it to the person or facility named in Section 3. If I am a birth mother signing this authorization on behalf of my minor child, I acknowledge that the minor's records may also include my sensitive health information related to mental health, substance abuse, infectious disease (including, without limitation, HIV/AIDS confidential information, venereal disease, tuberculosis, or hepatitis) or genetic testing, and I hereby consent to the disclosure of my sensitive health information in my minor child's record and waive any privilege concerning such information for the purpose of releasing it to the person or facility named in Section 3.

Note: Please read this form in its entirety and complete all applicable lines below. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) you are legally authorized to have access to the patient's medical records. ***You may be asked for additional documentation.***

_____ _____

Signature of Patient or Legal Representative Date/Time

_____

Relationship to Patient If Not the Patient

_____

Reason Patient Unable to Sign

_____ _____

Date Received Processed By

Please return completed form via person, via email medicalrecords@applinghospital.org, or via fax (912)366-6030.