

DOCTORS HOSPITAL - AUGUSTA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	Birth Date:	Social Security No:	
Date:	Requestor's Name:		
Patient Identification:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire 90 days from the date signed.

Purpose of disclosure:

For Treatment Dates: Specify all dates. This line must be completed.

Type of Access Required		Date(s):
<input type="checkbox"/> Copies of the record	Information Requested: -	
<input type="checkbox"/> Inspection of the record		

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary, however, records will only be released by signing this form.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor 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.
5. I understand that I may obtain a copy of the information described on this form, for a reasonable copy fee.
6. I may request a copy of this form after I sign it.

Section B: Signature(s)

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Parent or Guardian:	Date:
Print Name of Patient/Parent or Guardian:	Relationship to Patient:

Fee charges comply with all Georgia State laws and regulations applicable to release of information