I hereby authorize South Georgia Medical Center to ( ) release ( ) receive information from the Medical Records of:

Patient: _____ SS #: _____

(Print Last Name, First Name, Middle Name)

Date of Birth: _____ Date of Service: _____

Information to be released( ) to ( ) from _____

Tel. # _____ Address: _____

_____

If information is to be released to SGMC, please fax to # . . . . . Dept: . . . . . .

The following information is to be released: _____

_____

Information is needed for: ( ) Personal Request ( ) Other: _____

_____

I understand that information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. (Federal law prohibits the re-disclosure of the above information without written consent of the patient or authorized representative).

I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Records Director or designee. I understand that the revocation will not apply to any information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date below.

I understand that authorizing the disclosure of this health information is voluntary, and that I need not sign this form in order to assure treatment.

I understand that any disclosure of information has the potential for an unauthorized redisclosure and that the re-disclosure may not be protected by federal confidentiality rules.

Date: _____

Name of Requestor _____

(Patient or Authorized Person)

Signature: _____

Relation to Patient: _____

(If other than patient)

Witness: _____

SOUTH GEORGIA MEDICAL CENTER
Valdosta,GA

AUTHORIZATION FOR
RELEASE OF INFORMATION


9206459

South Georgia Medical Center
P.O. Box 1727
Valdosta, GA 31603-1727
Attention: Medical Records

Name: _____

D.O.B. _____ Age: _____

Acct #: _____ MR #: _____

Dr.: _____ Rm #: _____