AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Dodge County Hospital, 901 Griffin Ave, Eastman GA 30123.HIM Phone:(478)448-4036 FAX:(478)374-5266

MR#____________________(Office Use) **Account#**____________________(Office Use)

I authorize and request the disclosure of protected health information FROM:

☐ Dodge County Hospital
☐ Other (specify):____
Name/Organization Address Phone/FAX

to release health information about the following patient:

Patient Name:___________________________ Date of Birth:__________ Telephone#:__________

Street Address::_________________________ City/State/ZipCode:__________________________

You are authorized to release the above records TO the following: ☐ Myself/Patient – address as listed above

Name/Organization:______________________________ Phone::__________FAX:__________

Street Address::_________________________ City/State/ZipCode:__________________________

I expressly request that information be disclosed for the following patient types and date(s) of service:

☐ Inpatient: Dates:______________________ ☐ Outpatient/Same Day Surgery: Dates:______________________ ☐ Emergency Room: Dates:______________________

to include the following:

☐ Inpatient Abstract – History & Physical, Consultations, Discharge Summary, Operative Report, Lab Reports, Radiology Reports, Other Diagnostic Reports, Emergency Room Record

☐ Continuity Care Documents – Diagnostic Test Results, Problem List, Medication Lists, Medication Allergies, Discharge Summary, Procedures

☐ History & Physical ☐ Discharge Sumary ☐ Consultations ☐ Operative Reports
☐ Lab Reports ☐ Pathology Reports ☐ Radiology Reports ☐ Emergency Room
☐ Physician Orders ☐ Progress Notes ☐ Discharge Instructions ☐ Behavioral Health
☐ Other Specify______________________________

This protected health information is disclosed for the following purpose(s):
☐Continuing Care/ Dr needs ☐Patient/Representative's Request ☐Insurance ☐Legal ☐ Other (specify):__________

By Delivery Method: ☐ Pick-up ☐ Mail US Postal Service ☐ FAX ☐ Electronic Media

My Rights and My Authorization:

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that my treatment or payment cannot be conditioned on the signing of this authorization. II understand that unless expressly limited by me in writing, I am **specifically authorizing** the release of any sensitive medical information that may appear in my medical record including records for pain management, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric conditions, and/or alcohol and drug abuse. I can revoke this authorization at any time, except to the extent information has been released in reliance upon this authorization. Revocation must be signed and dated later than the date on this authorization and submitted to Dodge County Hospital HIM Department, 901 Griffin Ave., Eastman, GA 30123. The revocation will not affect any actions taken before the receipt of the written notification. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. This authorization will expire in 90 days from the date of execution of this authorization unless another date or event is entered here:________________

______________________________ ______________ ______________
Patient Signature or Legal Authorized Representative Date Time

______________________________ ______________________________
Print Name Relationship to Patient, if not signed by patient

☐ Legal authorized patient representative proof obtained and attached to this authorization _______ - Staff initials

CONTROLLED Document. Any documents in paper form must be used for reference purposes only and not copied. The on-line copy must be considered the Current documentation