MOREHOUSE HEALTHCARE
Health Information Management Department
1513 East Cleveland Ave., Bldg. 500
East Point, GA 30344
Telephone: (404) 752-1000
Fax: (404) 752-1191

Patient Name: _____

Mailing Address: _____

_____

Date of Birth: _____

Daytime Phone #: _____

Email Address:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I AUTHORIZE:

_____
Name of sending organization /entity

_____
Street Address

_____
City State Zip Code

TO RELEASE TO:

_____
Name of receiving individual(s), organization /entity

_____
Street Address

_____
City State Zip Code

Information to be released: (Please specify below date of service to be disclosed)

☐ All Medical Information* **or** ☐ Limited Information to only those item(s) checked below:

☐ Physical Examination records _____ ☐ Eye Examination _____ ☐ Immunization records _____
☐ Clinical/Progress Notes _____ ☐ OB/GYN _____ ☐ Laboratory Reports _____

☐ Other (Specify) _____ ☐ **ITEMIZED STATEMENT**

Medical Record Method of Delivery Option: ☐ Postal Mail ☐ Pick-Up ☐ E-mail ☐ Fax

To Request Release of Specifically Protected Information, You Must Initial Below:

☐ Alcohol & Drug Use Records _____ ☐ Mental Health Records_____ ☐ HIV/AIDS Records _____
☐ Sexually Transmitted Disease (STDS) _____

Reason for Disclosure:

☐ Treatment/Continuity of Care ☐ Personal Use ☐ Insurance ☐ Social Security
☐ Legal ☐ Workers' Comp ☐ Consultation ☐ Other (Specify) _____

- ☐ I understand that I, or the person authorized to act on my behalf, am entitled to receive a copy of this authorization.
- ☐ The requestor may be provided with a copy of this authorization.
- ☐ I understand that I may inspect my records and that a reasonable fee may be charged for duplication of records. An estimate of charges will be provided upon request before duplication.
- ☐ I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I also understand that this authorization **shall expire 45 days from the request date**, unless I specify another date: *Specify date here:* _____. If I decided to revoke this authorization, I will submit my written request to the Supervisor, Medical Records to the address above.
- ☐ I am authorizing any physician, nurse, hospital or other provider having treated or attended me and having possession of any records and/or information with respect thereto, to provide such records to the requesting party identified above.

By signing below you are hereby authorizing the above named sending entity to release the requested information identified above.

_____ _____
Date Signature, Parent or Legal Guardian / Witness

_____ _____
Notary Signature Relationship (if other than patient)

_____ _____
Notary Seal Commission Expires

*NOTE: If this release pertains to alcohol or drug abuse information, please note that this information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (§2 C.F.R. Part 2) prohibits you from asking further disclosure of it without the specific written consent of the patient to who it pertains or as otherwise permitted by such regulations.