SOUTHEAST GEORGIA HEALTH SYSTEM

I. Please Designate a Campus: ☐ **Brunswick Campus** ☐ **Camden Campus** ☐ **Senior Care Center-Brunswick** ☐ **Senior Care Center-St. Marys** ☐ **Health System Physician Practice:** ____________________

Authorization to Release Medical Information

I do hereby authorize and request Southeast Georgia Health System – **as designated above** - to release and disclose protected health information of:

Patient Name: ____________________ Date of Birth: ____________________

Address: ____________________ Phone #: ____________________

City/State/Zip ____________________ Other: ____________________

To the Following Person, Agency or Health Care Provider, if other than myself:

Name: ____________________ Phone #: ____________________

Address: ____________________ Fax #: ____________________

II. Request for Patient Portal access ☐ yes, send invitation to email address: ____________________
Last Four SSN Required for Portal:__________. ☐ Proxy e-mail provided Note: Section III does not apply to Patient Portal. Additional e-mail addresses: ____________________

III. Dates of Visit: ____________________

Please initial ALL that MAY NOT be included in the request: _______ Drug Abuse documentation, ____ Alcohol Abuse documentation, ______ HIV Testing and Results documentation, ________Mental Health documentation, _______ Genetic Testing , ______Other ____________________

Please specify the Protected Health Information to be released by checking the following:

Entire Record: ☐ **Abstract Record:** ☐ *does **not** include: nursing notes, physician orders, routine vital signs, progress notes, medication record, and rhythm strips ☐ Electronic Delivery (patients only) to email address above

Specific Documentation:

- ☐ Lab/Pathology
- ☐ Radiology Reports/MRI/CT/PET
- ☐ History and Physical/Consults
- ☐ Discharge Summary
- ☐ Emergency Room Record
- ☐ Rehabilitation Record (PT/OT/Speech therapies)
- ☐ CD Disc of: (circle) Radiology Studies / Cardio Studies / Other
- ☐ Operative/Procedure Report
- ☐ Cardiac Study/EKG/Echo
- ☐ Neurology Testing Results/EEG
- ☐ Respiratory Testing Results/PFT
- ☐ Pathology Report

Optional -the Purpose of this disclosure is for: ☐ Medical Care ☐ Personal (own use) ☐ Insurance Processing ☐ Legal

- By signing this Authorization, I am giving the Health Care Provider permission to disclose confidential health records. I also, understand that there is potential that the recipient may re-disclose provided information.
- I may withdraw (revoke) this Authorization in writing. Withdrawal of the Authorization does not affect any disclosure of protected health information made prior to the receipt of written notice. This authorization is in effect for **180 days** from the date of signature.
- There is a potential that information disclosed may be re-disclosed by the recipient of the records and may no longer be protected by law.
- A fee may apply for copies of the personal heath information that I receive. **The fee is waived when medical records are sent directly to a HealthCare Provider. (__________ Patient/Representative Initials)**

IV. SIGNATURE: ____________________ **DATE:** ____________________
(Signature of Patient/Legally Authorized Representative)

____________________ WITNESS: ____________________
(Relationship to Patient/Description of Authority to Act)

Request obtained by: _______ (initials) Prepped by: _______ (initials) Released by: _______ (initials)
Comments for Electronic Log: ____________________
Page Count: ____________ MR#: ____________ Acct#/DOS: ____________