



# SOUTHEAST GEORGIA HEALTH SYSTEM

Please Designate a Campus:  Brunswick Campus  Camden Campus  Senior Care Center-Brunswick  
 Senior Care Center-St. Mary's  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: \_\_\_\_\_

**Electronic Copy by**  E-mail or on  CD: **E-mail Address:** \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Date(s) 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

#### Specific Documentation:

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

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 health information that I receive. **The fee is waived when medical records are sent directly to a HealthCare Provider. (\_\_\_\_\_ Patient/Representative Initials)**

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: \_\_\_\_\_