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706-546-0832
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Patient Name: _____

I authorize the use and disclosure of the above-named patient's protected health information as described below.

Organization authorized to release the information: _____

Release information to: _____

Purpose of request: _____

Information to be released for the following dates: From: _____ To: _____

I understand that information in my health record may include information relating to HIV/AIDS confidential information, and may include psychosocial, mental health or alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Director of Medical Records. This would not apply to information that has already been released prior to my written revocation. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
I understand that information disclosed under this authorization may be subject to redisclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign this authorization.

_____ _____
Signature of Patient or Legal Representative Date

Printed name of Patient/Legal Representative _____

If signed by Legal Representative, describe relationship to patient_____

Patient Name: _____

Date of Birth: _____ SSN_____