Good Samaritan

HEALTH & WELLNESS CENTER

175 Samaritan Drive. Jasper. Georgia 30143
Phone 706.253.4673 Fax 706.253.4679

Patient Authorization for Disclosure of Protected Health Information (PHI) From GSHWC

Patient Name:______________________________ DOB:__________

Address:______________________________

Phone(s): Cell______________________ Home______________________

I request that my protected health information (PHI) from Good Samaritan HWC be disclosed to:

Recipient Name:______________________________

Address:______________________________

Phone:______________________ Fax:______________________

I authorize the following PHI to be released from my medical records:

Complete Medical Records covering the period of healthcare from:

Specific Dates: __/__/__ to __/__/__, or __ all past, present, future encounters or the following:

Laboratory Report	Date: __/__/__ or All __	Pathology Report	Date: __/__/__ or All __
Radiology film/imaging studies/media	Date: __/__/__ or All __	Radiology Report	Date: __/__/__ or All__
Itemized Billing Records	Date: __/__/__ or All __	Immunization Records	Date: __/__/__ or All__
Consult/Test Results of __________	Date: __/__/__ or All __	Other:__________	Date: __/__/__

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, *please initial*, indicating that you would like this information released/obtained:

____ Alcohol, Drug or Substance Abuse Records
____Mental Health Records
____Genetic Records
____HIV Testing/Results
____Psychotherapy Records

Purpose for requesting information:

__Legal
__Insurance
__Personal
__Continuation of Care
__Other__________________

Disclosure Format:

__Paper/US Mail
__Paper/Pick Up, by whom______________________
__Fax
__Other______________

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time in writing to Good Samaritan HWC. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event:_______. If I fail to specify an expiration date/event, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

______________________________ ____________

Patient or Authorized Representative Signature Date

______________________________ ____________

Print Name Relation to Patient