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 Others

Patient Name:_____ DOB:_____

Address:_____

Phone(s): Cell_____ Home_____

I request that my protected health information (PHI) from _____

Address:_____

Phone:_____ Fax:_____

Be disclosed to Good Samaritan Health & Wellness Center, 175 Samaritan Dr., Jasper, Ga 30143

Phone: 706-253-4673 ext 227 Fax: 706-253-4679

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__

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