AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information before completing and signing the authorization form.

Patient's Name: _____
(Please Print) LAST FIRST MI

Birth date: _____

Are medical records filed under another name? _____ Phone Number: _____

INFORMATION TO BE RELEASED ***BY:***	INFORMATION TO BE RELEASED ***TO:***
Islands Family Medical Center 100 Blue Fin Circle Suite 7 Savannah, GA 31410 Phone: 912.897.6832 Fax: 912.897.7151	Organization name: _____ Address: _____ _____ _____ Phone: _____ Fax: _____

TYPE OF MEDICAL INFORMATION REQUESTED:

- ❑ Complete medical record (includes chart notes, most recent labs/pathology & diagnostic imaging reports)
- ❑ Cancer Partnership records ❑ Radiology/ Diagnostic Imaging Reports ❑ Mammogram Diagnostic Imaging Reports
- ❑ Echocardiograms ❑ Pharmacy ❑ Behavioral Health records only
- ❑ My health information relating only to the following treatment or condition:
- ❑ My health information only for the following date(s):
- ❑ Other:

REASON FOR REQUEST: ❑ Personal ❑ Transfer of Care ❑ Disability ❑ Insurance ❑ Legal Review ❑ Continuing Care

❑ Other (please explain):

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I **understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).**

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

This authorization expires _____ (date or event). Authorization will expire in 90 days if not otherwise specified.

Patient signature _____

Date _____

Parent or Legal Guardian _____

Date _____

Relationship to patient, if other than patient
(You may be required to provide legal documentation as proof for power of attorney or guardianship)

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.