AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name ____
(Last) (First)

Patient SS# ____________________ DOB _________________

Patient's Address______________________________________
(Street, P. O. Box)

____________________________ ________
(City) (State)

Date(s) of Treatment _________________ Specify Information to be released______________

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I hereby authorize Peach Regional Medical Center to release copies of my medical records as specified above to:

Name____

Address ________________________________ Phone Number ____________________________

____ Fax Number ___________________________

Describe the specific purpose (s) for which you authorize Peach Regional Medical Center use or disclosure of this Protected Health Information ____

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(You must include each purpose of the requested Use or Disclosure, but may state "at the request of the individual" if the individual is initiating the Authorization and does not, or elects not to, provide a state of the purpose)

All information authorized by myself to be released is confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for 90 days.

I understand that these records may contain specific conditions relating to psychiatric treatment, substance abuse, adoption investigation, suspected child/adult abuse, AIDS or HIV information (including documentation of counseling, and other infectious diseases.

HIPAA Privacy Rule. I have the right to revoke this Authorization in writing, except (i) to the extent that the Facility has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to Peach Regional Medical Center, 601 N. Bluebird Boulevard, Fort Valley, Georgia 31030 by sending a written request stating that I wish to revoke this Authorization to the attention of the Privacy Officer.

Signature of Patient____ Date ______________________

Signature of Parent or Legal Guardian ______________________________ Date ______________________

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Relationship to Patient

Prohibition of Disclosure: Federal Law (42 CFR Part 2) and HIPAA 1996 prohibit further disclosure of this information except with written consent from the person to whom it pertains. A general authorization for the release of medical or other information if held by another part is not sufficient for this purpose.

Date Information released ______________________ by __________________________
(Staff Name)