



**Authorization for Release/Disclosure of Medical Information**

Please **REQUEST** Medical Information **FROM:**

Please **SEND** Medical Information **TO:**

**ELH Medical Records Department**

\_\_\_\_\_  
Name of Medical Office/Hospital

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Phone Number/Fax Number

\_\_\_\_\_  
Name of Medical Office/Hospital

**1502 W 3rd Street**

\_\_\_\_\_  
Street Address

**Jackson, GA 30233**

\_\_\_\_\_  
City, State and Zip Code

**678-774-0430 678-826-5911**

\_\_\_\_\_  
Phone Number/Fax Number

**I hereby authorize \_\_\_\_\_ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.**

_____ Full Name of Patient	_____ Date of Birth	_____ Telephone Number
_____ Address	_____ State	_____ Zip Code

**Duration:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for one year from the date of signature if no date entered.

**Revocation:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

**Redisclosure:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

**Specify Records to be Released/Disclosed:**

*(Check which information is to be released/disclosed; If not specified 2 years will be provided by default)*

- General Medical Information** (from \_\_\_\_\_ to \_\_\_\_\_)
- Information Regarding Specific Injury or Treatment** (from \_\_\_\_\_ to \_\_\_\_\_)
- X-Ray** (check one or both): {} **Films** {} **Reports**
- Laboratory Results**
- Mental Health** (from \_\_\_\_\_ to \_\_\_\_\_)
- Alcohol/Drug** (from \_\_\_\_\_ to \_\_\_\_\_)
- HIV Test Results** (from \_\_\_\_\_ to \_\_\_\_\_)
- Other** (specify): \_\_\_\_\_

_____ Signature of Patient	_____ Date
_____ Signature of Patient	_____ Date
_____ Signature of Patient	_____ Date

I request that the health information released/disclosed pursuant to this authorization be used for the following purposes only: Review of Medical Records

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.  
*By signing this release form, you are giving Medical Office/Hospital authorization to send records by email.*

_____ Date	_____ Signature of Patient or Representative	_____ Relationship to Patient
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