



MOREHOUSE HEALTHCARE
Health Information Management Department
 1513 East Cleveland Ave, Bldg. 500
 East Point, GA 30344
 Telephone: (404) 752-1000
 Fax: (404) 752-1191

Patient Name: _____
 Mailing Address: _____

 Date of Birth: _____
 Daytime Phone #: _____
 Email Address: _____

**AUTHORIZATION TO RELEASE
 PROTECTED HEALTH INFORMATION**

I AUTHORIZE:

TO RELEASE TO:

 Name of sending organization /entity

 Name of receiving organization /entity

 Street Address

 Street Address

 City State Zip Code

 City State Zip Code

Information to be released: (Please specify below date of service to be disclosed)

- All Medical Information* **or** Limited Information to only those item(s) checked below:
 Physical Examination records _____ Eye Examination _____ Immunization records _____
 Clinical/Progress Notes _____ OB/GYN _____ Laboratory Reports _____
 Other (Specify) _____

ITEMIZED STATEMENT ATTACHED

Medical Record Method of Delivery Option: Postal Mail Pick-Up E-mail Fax

To Request Release of Specifically Protected Information, You Must Initial Below:

- Alcohol & Drug Use Records _____ Mental Health Records _____ HIV/AIDS Records _____
 Sexually Transmitted Disease (STDS) _____

Reason for Disclosure:

- Treatment/Continuity of Care Personal Use Insurance Social Security
 Legal Workers' Comp Consultation Other (Specify) _____

- I understand that I, or the person authorized to act on my behalf, am entitled to receive a copy of this authorization.
- The requestor may be provided with a copy of this authorization.
- I understand that I may inspect my records and that a reasonable fee may be charged for duplication of records. An estimate of charges will be provided upon request before duplication.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I also understand that this authorization **shall expire 45 days from the request date**, unless I specify another date:
Specify date here: _____. If I decided to revoke this authorization, I will submit my written request to the Supervisor, Medical Records to the address above.
- I am authorizing any physician, nurse, hospital or other provider having treated or attended me and having possession of any records and/or information with respect thereto, to provide such records to the requesting party identified above.

By signing below you are hereby authorizing the above named sending entity to release the requested information identified above.

 Date

 Signature, Parent or Legal Guardian / Witness

 Notary Signature

 Relationship (if other than patient)

 Notary Seal

 Commission Expires

*NOTE: If this release pertains to alcohol or drug abuse information, please note that this information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (§2 C.F.R. Part 2) prohibits you from asking further disclosure of it without the specific written consent of the patient to who it pertains or as otherwise permitted by such regulations.