Place Patient Label Here

Phoebe

PHOEBE PHYSICIAN GROUP
ALBANY, GEORGIA
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Patient Address:_____ City:_____ State/Zip:_____

Last 4 of SSN:_____ Telephone #:_____

Email Address:_____

By signing below, you hereby authorize Phoebe Physician Group to disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. Unless specifically excluded below, information to be disclosed will include all diagnoses and treatments, including psychiatric conditions, drug/alcohol/chemical addiction and/or treatment, HIV /AIDS, and other privileged information. Subject to certain exceptions, you have the right to inspect and receive a copy of protected health information.

Information to be disclosed (must be identified in a specific and meaningful fashion):

- ☐ General Abstract (includes as applicable Discharge Summary, History & Physical, Operative Report, Consultation Report, and Pathology Report)
- ☐ Emergency Center Records
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Discharge Summary
- ☐ Pathology Report
- ☐ Complete Record
- ☐ Other Records:_____

Visit dates to be disclosed:_____

Visit dates and/or information that *may not* be disclosed:_____

_____

Purpose of the use and disclosure: _____

_____

Records are to be disclosed to:_____

_____

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

_____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization. You have the right to request and receive a copy of this authorization.

THERE IS A CHARGE FOR COPIES OF MEDICAL RECORDS.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

_____

Please Provide Copy of Photo ID

Clinic Name: _____

ATTN: Medical Records

Clinic Address: _____

Clinic Phone: _____

Clinic Fax: _____

Clinic Email: _____