Central Georgia Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Central Georgia Fertility Institute
4075 Elnora Drive
Macon, GA 31210

Please complete this authorization by printing legibly, sign and date.

I authorize and request the disclosure of protected information from:

_____
Name of Healthcare Facility to release medical information

_____
Street Address

_____
City, State and Zip Code

to release health information about the following patient:

_____ _____
Print Patient Name: Date of Birth

_____ _____
Street Address Telephone Number

_____
City, State and Zip Code

I expressly request that the information in the designated record set be disclosed for date(s) of service: _____ to include the following:

☐ History & Physical	☐ Lab Reports	☐ Physicians' Orders
☐ Discharge Summary	☐ Radiology Reports	☐ Cardiovascular Diagnostic Reports
☐ Consultations	☐ EKG	
☐ Operative Reports	☐ Emergency Center	☐ Urgent Care Records
☐ Pathology Reports	☐ Progress Notes	☐ Hospice Records
☐ Outpatient Rehab Records	☐ Health Center / Clinic	☐ Other (specify): _____

This protected health information is disclosed for the following purpose(s):

☐ Insurance ☐ Continued Treatment ☐ Legal
☐ Patient's / Representative's Request ☐ Other, specify_____

You are authorized to release the above records to the following:

_____
Name Title

_____
Street Address

_____
City, State and Zip Code

 Initials of patient or representative:_____

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I understand the following:

a) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization and submitted to Health Services of Central Georgia, Medical Records Department, 740 Hemlock St., Suite D, Macon, GA 31201 . The revocation will not affect any actions taken before the receipt of the written revocation.

b) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

CGHS healthcare entities and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric conditions, and/or alcohol and drug abuse. I authorize the release or disclosure of this type of information.

_____ _____

Signature of Patient or Legal Authorized Representative **Date**

I understand that this authorization will expire in 90 days from the date of execution of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.

Expiration date and/or event

_____ _____

Signature of Patient or Legal Authorized Representative **Date**

_____

Print Name

_____ _____

Relationship if other than patient **Street Address**

_____ _____

Telephone Number **City, State and Zip Code**

Office Use

☐ Legal authorized representative proof obtained and attached to this authorization

MR #: _____