EVANS MEDICAL GROUP

706-868-3100/706-228-3125 Fax

I, _____, authorize the following protected health information
Person Authorizing Release

Release from the medical record of:

_____ /_____
Patient's Last Name First Name MI Patient's Date of Birth Social Security Number

_____
Street Address City State Zip

Evans Medical Group
465 N. Belair Rd, Suite 1-B
Evans, GA 30809
Fax: 706-228-3125

Records Released to: (Name of Physician/Facility)
_____
Address: _____
City, State, Zip:_____
Phone:_____Fax:_____

Reason for Release of information:

_____
Please note specific dates or information to be obtained:

Amount of records and type of records released will be subject to the Evans Medical Group Records Release Policy.

I have read and understand the Evans Medical Group Release of Records Policy and Protocols. I authorize Evans Medical Group together with its employees, agents and contractors, to use or disclose the above individual's protected health information (PHI) covered under the regulations pursuant to the Health Insurance Portability and Accountability Act of 1996.
I understand that PHI may include information protected under law, such as alcohol or drug abuse treatment information, mental health related communications or treatment information, or information regarding sexually transmitted diseases including HIV or AIDS testing or treatment. I understand that PHI may include health information records of the patient disclosed to Evans Medical Group by other health care providers. This authorization does not limit Evans Medical Group's ability to use and disclose this health information in accordance with Evans Medical Group's Notice of Privacy Practices.
I understand that I may revoke this authorization at any time by submitting a written revocation letter provided by the authorized signer of this release. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one year from the original signature date.
I understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment unless the provision of healthcare is for the purpose of creating PHI for disclosure to a third party (e.g. an employee physical exam). I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact management at Evans Medical Group.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on Patient's behalf. I hereby release Evans Medical Group and its officers, trustees, employees, and contractors from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

_____

SIGNATURE OF PATIENT **Relationship** **DATE**
PARENT / LEGAL REPRESENTATIVE

If completing on behalf of another adult, a signature is required from that individual. If you have Power of Attorney on behalf of another individual, please provide us with a copy of the legal document. POA copy attached._____