EVANS MEDICAL GROUP

Authorization for Disclosure of Protected Health Information (PHI)
Release of Medical Records from another facility to Evans Medical Group

I, _____, (Person Authorizing Release) authorize the following protected health information: Release from the medical record of

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

_____
Street Address City State Zip

Medical Records Released from (Name of Physician/Facility/Other):	Medical Records Released to:
_____	Evans Medical Group
Address:_____	465 N Belair Road, Suite 1B,
City, State, Zip_____	Evans Georgia 30809
Phone _____Fax_____	706-868-3100 /706 228-3125 (fax)
	Purpose: Physician coordination of care

NOTE: WE CANNOT ACCEPT RECORDS IN A DISC, MUST BE IN PAPER FORM.

*****Please send the following:**

( ) Most Recent office note ( ) Last 12 months ( ) Immunization record

( ) Last colonoscopy ( ) Last Pap smear ( ) Last mammogram ( ) Other_____

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 request of my protected health information pursuant to this Authorization.

X_____

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. _____


EMG
EVANS MEDICAL GROUP