



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

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): _____ Address: _____ City, State, Zip _____ Phone _____ Fax _____	Medical Records Released to: Evans Medical Group 465 N Belair Road, Suite 1B, Evans Georgia 30809 706-868-3100 (phone) 706 228-3125 (fax)
--	--

*****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 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. _____