

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This section must be completed for all Authorizations.

Patient Name:	Birth Date:	Social Security No. (optional):	
Provider's Name: Taylor Regional Hospital	Recipient's Name:		
Provider's Address: 222 Perry Highway Hawkinsville, Georgia 31036 Phone - 478-783-0271 Fax - 478-783-0274	Address:		
	City:	State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.)			
Date:		Event:	
Purpose of Disclosure:	Date of Records requested:		

Description of information to be used or disclosed

<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission Form <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical Examination <input type="checkbox"/> Consultations <input type="checkbox"/> Operative Information <input type="checkbox"/> Itemized bill/UB-92 <input type="checkbox"/> Confidential Information regarding AIDS or HIV <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Laboratory Tests <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Physician Orders/Progress Notes <input type="checkbox"/> Nursing Information <input type="checkbox"/> ER/Ambulance Information <input type="checkbox"/> Photographs, X-ray films, other images <input type="checkbox"/> Medication Sheets <input type="checkbox"/> Diagnosis/Treatment and/or referral for Alcohol and/or Drug Abuse <input type="checkbox"/> Psychotherapy Notes (only item you may request on this authorization)
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I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here.

- I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
 4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
 6. I get a copy of this form after I sign it upon request.

SIGNATURES

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Patient's Representative: _____ Print Name of Patient's Representative: _____	DATE AND TIME: _____ RELATIONSHIP TO PATIENT: _____
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To be completed by TRH personnel only:

<input type="checkbox"/> Release completed	Date: _____	By: _____
<input type="checkbox"/> Unable to complete Release due to : <input type="checkbox"/> Information not available <input type="checkbox"/> Authorization not complete <input type="checkbox"/> unable to identify patient <input type="checkbox"/> Other _____		

