Place Patient Label Here

Phoebe

PHOEBE PUTNEY MEMORIAL HOSPITAL

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Patient Address:_____ City:_____ State/Zip: _____

SSN: _____ Telephone #:_____

Email: _____

By signing below, you hereby authorize PPMH to disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. Unless specifically excluded below, information to be disclosed will include all diagnoses and treatments, including psychiatric conditions, drug/alcohol/chemical addiction and/or treatment, HIV/AIDS, and other privileged information. Subject to certain exceptions, you have the right to inspect and receive a copy of protected health information.

Information to be disclosed (must be identified in a specific and meaningful fashion):

☐ General Abstract (includes as applicable Discharge Summary, History & Physical, Operative Report, Consultation Report, Pathology Report, Radiology and Lab)

☐ Emergency Center Records ☐ Discharge Summary

☐ Radiology Reports ☐ Pathology Report

☐ Laboratory Reports ☐ Complete Record

☐ Other Records: _____

Method of disclosure (choose only one):

☐ Paper/Pick Up ☐ Paper/Mailed ☐ Disc/Pick Up ☐ Disc/Mailed

Visit dates to be disclosed: _____

Visit dates and/or information that ***may not*** be disclosed: _____

_____

Purpose of the use and disclosure: _____

_____

ROI

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Records are to be disclosed to: _____
_____
_____

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):
_____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization. You have the right to request and receive a copy of this authorization.

IN MOST CIRCUMSTANCES THERE IS A CHARGE FOR COPIES OF MEDICAL RECORDS
GENERAL ABSTRACTS ARE FREE OF CHARGE
(Payment must be made prior to method of disclosure)

_____ _____
Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

_____

Please Provide Copy of Photo ID

Release can be mailed, faxed or emailed back to:
Phoebe Putney Memorial Hospital
Medical Records Dept
417 Third Avenue (31701)
P.O. Box 3770
Albany, Georgia 31706
Fax: 229-312-6005
Phone: 229-312-6000
Email: HIMROI@phoebehealth.com

ROI