Clinch Memorial HOSPITAL

P.O. Box 516
Homerville, GA 31634

Phone: 912-470-2507
Fax: 912-470-2335

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized Clinch Memorial Hospital to release / receive information from the Medical Records of:

Patient _____ SS # _____
(Print Last Name, First Name, Middle Name)

Date of Birth: _____ Date of Service _____

Requested by: _____ Phone # _____

Release To / From: _____

_____

The following information to be released: _____

_____

Information is needed for ( ) Personal Request ( ) Other: _____

_____

I place no limitations and understand that the information to be released may refer to history of illness, diagnostic and therapeutic information, including any treatment for alcohol or drug abuse / dependency; psychiatric or psychological conditions, mental illness or retardation, sexually transmitted disease, AIDS, or HIV. 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.

I understand that I have a right to revoke this authorization at any time by presenting a written revocation to Health Information Management or designee. I understand that the revocation will not apply to any information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that any disclosure of information has the potential for an unauthorized re-disclosure and that the re-disclosure may not be protected by federal confidentiality rules.

Date/Time: _____ Signature: _____
(Patient or Authorized Person)

Relationship to Patient: _____
(If other than patient)

Witness: _____

Date/Time: _____

This authorization is valid for ninety (90) days from the date of signature.

OFFICE USE ONLY

Request taken by: _____ Date: _____

- o Call back
- o Pick –Up
- o Mail Copies
- o Fax FAX/EMAIL #_____
- o Email

I.D. Check: _____(Driver's license, I.D. Badge)