



## Authorization for Release of Medical Information

1506 Alice Street  
Waycross, GA 31503  
Fax: (912) 285-9595

Patient Name:	
Birth Date:	Social Security # (last 4 digits only):
Address:	Telephone #:

I hereby authorize:

Organization/Person Name:	Telephone #:
Address:	Fax #:

To release the following medical information about me to:

Organization/Person Name:	Telephone #:
Address:	Fax #:

**Medical Information to be Released:**

Psychotherapy Notes. (If you are requesting Psychotherapy Notes, then you may not release any other information with this authorization, and you may not check any of the other boxes in this section. To release your other records, you must submit a separate authorization.)

<input type="checkbox"/> History & Physical	<input type="checkbox"/> Stent or Angioplasty	<input type="checkbox"/> Echo
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultations	<input type="checkbox"/> EKG
<input type="checkbox"/> Heart Catheterization	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Stress Thallium
<input type="checkbox"/> Open Heart Surgery Report	<input type="checkbox"/> Radiology	<input type="checkbox"/> Other Medical Information _____
<input type="checkbox"/> Complete Record (excluding Psychotherapy Notes, if any) _____		

**DATES OF SERVICE NEEDED:**  From \_\_\_\_\_ to \_\_\_\_\_

All Dates of Service

Last Visit Only

**FOR THE FOLLOWING PURPOSE:**

<input type="checkbox"/> Continued Care	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Other _____
<input type="checkbox"/> Legal Reasons	<input type="checkbox"/> DCF	
<input type="checkbox"/> Insurance	<input type="checkbox"/> Personal Use	

I understand that the released information may include information relating to the diagnosis, treatment and/or examination of alcohol and drug use; mental health (psychiatry/psychology/psychotherapy); and HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

I acknowledge that I am signing this authorization voluntarily. **St. Vincent's** and its affiliates will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may revoke this authorization in writing at any time, except to the extent already relied upon and except as stated in **St. Vincent's HealthCare's** Notice of Privacy Practices. Also, patients who believe information in their medical record is incorrect or incomplete may request an amendment of patient information. To revoke this authorization or request an amendment, contact **St. Vincent's HealthCare's** Privacy Officer.

The law prohibits recipients of this information from using it for other than the stated purpose. The law also prohibits recipients from making any further disclosure of this information without the specific written consent of the patient. However, I understand that **St. Vincent's HealthCare** and its affiliates cannot guarantee that recipients of the information will not use or re-disclose it contrary to such legal prohibitions, and the information may no longer be protected by privacy laws once it has been so used or re-disclosed. The law prohibits the disclosure of mental health records to certain individuals in some circumstances, which may include patients and their family members.

This authorization expires twelve months from the date listed below and covers only dates of service for the dates specified above.

**I have read and understand this authorization. I hereby authorize the release of the above-requested medial information about me.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Patient's Authorized Representative

\_\_\_\_\_  
Description of Representative's Authority to Act for Patient

\_\_\_\_\_  
Associate Name

\_\_\_\_\_  
Date Received