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:	**Recipient's Name:**
Bleckley Memorial Hospital	
Provider's Address:	**Address:**
145 E Peacock St	
Cochran, Georgia 31014	**City:** / **State:** / **Zip:**
Phone - 478-934-6211	
Fax - 478-271-4252	

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

☐ All PHI in medical record	☐Laboratory Tests
☐Admission Form	☐Radiology Reports
☐Discharge Summary	☐Physician Orders/Progress Notes
☐History and Physical Examination	☐Nursing Information
☐Consultations	☐ER/Ambulance Information
☐Operative Information	☐Photographs, X-ray films, other images
☐Itemized bill/UB-92	☐Medication Sheets
☐Confidential Information regarding AIDS or HIV	☐Diagnosis/Treatment and/or referral for Alcohol and/or Drug Abuse
☐Other: _____	☐Psychotherapy Notes (only item you may request on this authorization)
☐Other: _____	

I acknowledge, and hereby consent to such, that the released information my 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 my 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:**	**DATE AND TIME:**
_____ **Print Name of Patient's Representative:**	**RELATIONSHIP TO PATIENT:** _____

To be completed by BMH personnel only:

☐ Release completed	Date:	By:

☐ Unable to complete Release due to : ☐ Information not available ☐ Authorization not complete ☐ unable to identify patient ☐ Other _____

Patient Account #

_____