SHEPHERD CENTER
HEALTH INFORMATION MANAGEMENT
2020 Peachtree Road, NW
Atlanta, Georgia 30309
(404) 350-7493

Patient Name : _____

SS# : _____ Date of Birth: _____

Med. Rec. #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize: _____

_____

to use or disclose (a copy) of my health information as identified below to _____

_____

for the following purposes: ❒ Continuing Care and Treatment ❒ Insurance Claim ❒ Legal

❒ Personal Use ❒ Other, describe _____

By initialing the spaces below, I specifically authorize the use and disclosure of the following health information and/or medical records, if such information and/or medical records exist:

___ Discharge Summary/Discharge Note ___ History/Physical Exam ___ Consultation Reports

___ Progress Notes ___ Physician Orders ___ Nurses' Notes ___ Laboratory Reports

___ Diagnostic Imaging Reports ___ Therapy Notes, describe _____

___ Billing Statements

___ Entire Medical Record Including Nurses' Notes ___ Entire Medical Record Excluding Nurses' Notes

___ Other: _____

_____

_____

Specify period of time for which authorization applies: _____

_____

IF THIS AUTHORIZATION IS FOR THE USE OR DISCLOSURE OF PSYCHOTHERAPY INFORMATION, THEN IT CANNOT BE COMBINED WITH ANY OTHER AUTHORIZATION.

___ Psychotherapy Progress Notes ___ Psychotherapy Physician Orders ___ Psychotherapy Evaluation

___ Other (describe) _____

Specify period of time for which authorization applies: _____

Certain Other Health Information For Use or Disclosure

I understand that for certain information to be disclosed, state or federal laws and regulations require my specific written authorization as follows (please initial to verify authorized use or disclosure)

___ HIV / AIDS related health information ___ Genetic testing information and/or records

___ Mental health information and/or records ___ Drug/alcohol diagnosis, treatment or referral information

Federal regulations require a description of how much and what kind of information is to be disclosed. Describe information for use or disclosure:

___ Dictation Physician Reports ___ Progress Notes ___ Physician Orders ___ Lab and/or Other Diagnostics

___ Other (describe) _____

Specify period of time for which authorization applies: _____

I understand that if the person or entity receiving the information is not a health care provider or health care plan covered by federal privacy regulations, the information described above and on the reverse side of this page may be redisclosed and no longer protected by these regulations. The recipient may be prohibited from disclosing substance abuse information under the federal substance abuse confidentiality requirements.

I understand that the person I am authorizing to use or disclose the information may receive compensation for doing so. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be use or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authoriztion will expire 180 days from the date of the signing or until _____.

_____ _____

Signature of patient or patient's legal representative Date

_____

Print name of patient

_____ _____

Print name of patient's legal representative if applicable Relationship to Patient

___ Patient is unable to sign authorization but gives verbal approval for the use or disclosure of health information as described in this authorization.

Reason patient is unable to sign authorization : _____

_____ _____

Signature of witness Date

_____

Print name of witness