



Authorization for Disclosure of Health Information

PATIENT INFORMATION:

Print Name: Previous (If Applicable):
Date of Birth: MRN (if known):
Address: Apt/Unit:
City: State: Zip Code:
Phone Number: Email Address:

I authorize the release of health information of the above-named patient from:

Shepherd Center Other Facility:
Other Facility Address:
Phone: Fax:

PURPOSE OF RELEASE: Continuity of Care Legal Insurance Personal
Other:

RECIPIENT OF INFORMATION:

Please specify the one (1) person or facility you authorize to receive your health information:

Person/Facility:
Address:
City: State: Zip Code:
Fax (Continuity of Care Only): Phone:
Release format: Email CD Paper

DESCRIPTION OF INFORMATION TO BE RELEASED:

Dates of Service requested: to

Table with 3 columns: Hospital Visits (and/or) Outpatient Visits, Diagnostic Reports, Radiology Imaging. Each column contains a list of items with checkboxes and an 'Other:' field.



- Abstract (Discharge Summary, History and Physical, Therapy Evaluation Note, Consultations, Diagnostic Results and Labs)
- Entire Medical Record **with** Nurse's Notes (excludes Radiology CD and Billing)
- Entire Medical Record **without** Nurse's Notes (excludes Radiology CD and Billing)

Other: \_\_\_\_\_

**Special Categories of Records:** Certain records related to substance use disorders, mental health, and HIV/AIDS information have special protections and require you to specify if the information is to be included in this disclosure.

- Neuropsychology Report
- Psychotherapy Notes\*
- Substance Use Disorder Records
- HIV/AIDS Information
- Other: \_\_\_\_\_

**\*A separate authorization is required for psychotherapy notes and cannot be combined with a request for other types of records.**

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**By signing this Authorization form, I understand that:**

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- Except to the extent that Shepherd Center or another lawful holder of the information has already relied on this authorization, I understand that I have the right to revoke this authorization at any time by sending a written notice to Shepherd Center, Health Information Management Department, at the address noted below.
- This authorization will expire (please select **one** option below):
  - Once fulfilled.
  - Within \_\_\_\_\_ days of the dated signature.
  - At the end of my treatment relationship with Shepherd Center.
  - Other: \_\_\_\_\_
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the disclosed information may not be protected by federal confidentiality rules.
- Shepherd Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

\_\_\_\_\_  
Patient **OR** Authorized Representative\*\*\* Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient (if applicable)

\_\_\_\_\_  
Date

\*\*\*An Authorized Representative will need to provide proof along with this authorization.

- Patient 18+ and Incapacitated (unable to sign): GA Advanced Directive **OR** Healthcare Power of Attorney **OR** Letters of Guardianship/Conservatorship **OR** some other evidence of authority under GA law to act as patient's representative for purposes of this request.
- If the patient is deceased, please provide Letters of Executorship.
  - If a workers' compensation attorney is requesting records, please provide a GA WC207 or similar workers' compensation authorization form from another state.

**SUBMIT AUTHORIZATION:** Email: [roi@shepherd.org](mailto:roi@shepherd.org) OR Fax: 404-350-7772 OR Mail (see address below)