Authorization for Release of Medical Information

Patient Information

Patient Name:_____

Address:_____

_____

SS #:_____ **Date of Birth:**_____

Phone Number:_____ **Medical Record #:**_____

Recipient Information

Release Information to:_____
(Name of the person to whom the patient would like the information sent)

Address:_____

_____ **Phone Number:**_____

Purpose of Disclosure: *(Optional)*
Consult □ **Moving** □ **Changing Doctors** □ **Insurance Claim** □ **Legal Case** □
Today's Date:_____ **Request valid for 60 days**

Information to be Disclosed

Study Type_____ **Date of Service**_____

Study Type_____ **Date of Service**_____

Study Type_____ **Date of Service**_____

Staff Initials_____ **Photo ID:** _____

I hereby release Emory Johns Creek Hospital from any responsibility should the images be lost or misplaced. I authorize Emory Johns Creek Hospital to release the medical records requested above. I understand that I may refuse to sign this authorization and that it is strictly voluntary. My treatment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 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. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations an may be redisclosed. 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. I get a copy of this form after I sign it.

Patient Signature:_____ **Date:**_____

Signature of Patient's Representative:_____

Patient's Representative Authorization Letter attached: **Yes** ○ **No** ○
Photo Identification of Patient's Representative verified: **Yes** ○ **No** ○

EMORY JOHNS CREEK HOSPITAL

EMORY HEALTHCARE

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