Request for an Individual's Health Information

Last: **First:** **Middle:**

Other Names Used: **Date of Birth:** **SS#:**

Address:

Home Phone: ( ) **Work Phone: ( )**

☐ I hereby request access to the protected health information in my health record from (date) _____ to (date) _____ maintained or created by the following providers associated with the Paces Ferry Medical Group listed below.

[ ] Most recent Progress Note
[ ] Pathology/Lab Reports
[ ] X-rays Reports
[ ] Billing Records
[ ] Immunization Records
[ ] Entire Health Record
[ ] Other_____

[ ] I will pick up the copies of my records
[ ] Mail copies of my records to the individual noted below :

Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: __patient's request, __dispute, __referral, __other: _____

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules. The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____ _____ _____

Signature of Patient, Parent, or Legally Authorized Representative | Relationship to Patient | Date