



ımber:		
	(for internal nurnoses)	

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient	Name:	Last 4 digits of SSN:
Addres	ss:	Date of Birth:
City/St	tate/Zip:	Phone #:
	E-mail Address (for electronic disclosure and A	U Health VIP access)
AU H	(ealth Facilities (check all that apply)	
	AU Medical Center, Inc.  d/b/a AU Medical Center, Augusta University Medical Center, AU Health, Augusta University Health and Children's Hospital of Georgia	1120 15th Street BPM-120, Augusta, GA 30912 Health Information Management Services Phone 706.721.2948
	AU Medical Associates	1120 15th Street BPM-120, Augusta, GA 30912 Health Information Management Services Phone 706.721.2948
	Roosevelt Warm Springs Rehabilitation & Specialty Hospitals, Inc. d/b/a Roosevelt Warm Springs Institute for Rehabilitation and Roosevelt Warm Springs LTAC Hospital	6135 Roosevelt Highway, Warm Springs, GA 31830 Medical Record Department Phone   LTAC: 706.655.5408 IRF: 706-655-5473
	thorized the facility indicated above to use or disclose the above named in cerning the period from	
This	Standard Document Set (Discharge Summary, History and Physical, I Other (specify) Entire Medical Record (justification required):  Psychiatric/Psychological Information Drug/Alcohol Abuse Trea information may be disclosed to and used by the following individual or The:	tment Information
<b>A</b> ddı	ress:City/State/Zip: _	
Purp	oose:	
-	cial instructions:	
I und writin apply insur	derstand that I have a right to revoke this authorization at any time. I understaring and present my written revocation to the health information management do y to information that has already been released in response to this authorization rance company when the law provides my insurer with the right to contest a classification will expire on the following date, event, or condition:	nd that if I revoke this authorization I must do so in epartment. I understand that the revocation will not on. I understand that the revocation will not apply to my
If I fa	ail to specify an expiration date, event or condition, this authorization will expire	e in 90 days.
this f CFR infori	derstand that authorizing the disclosure of this health information is voluntary. Form in order to ensure treatment. I understand that I may inspect or copy the tale 164.524. I understand that any disclosure of information carries with it the potential may not be protected by federal confidentiality rules. If I have question act the Director of Health Information Management Services at (706) 721-2722	information to be used or disclosed, as provided in cential for an unauthorized re-disclosure and the s about disclosure of my health information, I can
Sign	nature of Patient or Legal Representative Date	Time
If Si	gned by Legal Representative, Relationship to Patient  Signature of	of Witness



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