Health
AUGUSTA UNIVERSITY

Medical Record Number: _____
(for internal purposes)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Last 4 digits of SSN: _____
Address: _____ Date of Birth: _____
City/State/Zip: _____ Phone #: _____

E-mail Address (for electronic disclosure and AU Health VIP access)

AU Health 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 706.655.5407

I authorized the facility indicated above to use or disclose the above named individual's health information as described below, concerning the period from _____ to _____.

☐ Medical Information, as specified:
- ☐ Standard Document Set (Discharge Summary, History and Physical, Progress Notes, Test Results, Consults)
- ☐ Other (specify) _____
- ☐ Entire Medical Record (justification required):

_____

☐ Psychiatric/Psychological Information ☐ Drug/Alcohol Abuse Treatment Information ☐ HIV/AIDS Information

This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____City/State/Zip: _____

Purpose: _____

Special instructions: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____.

If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management Services at (706) 721-2722.

_____ _____ _____
Signature of Patient or Legal Representative Date Time

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

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