



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize Mountain Lakes Medical Center to release the medical information of _____ which may include any and all records maintained by Mountain Lakes Medical Center to include Rabun County Hospital, Rabun County Memorial Hospital, and Mountain Lakes Community Health Care Clinic.

Treatment Facility: ___Mtn Lakes Medical Center ___Rabun County/Memorial Hospital ___Mtn. Lakes Community Health Care Clinic

Name at time of treatment, if other than above: _____ Nickname? _____

Date of Birth: _____ SS# _____ - _____ - _____ Date(s) of Treatment: _____

Release information to: Self Other _____

Mailing/Faxing to: _____ (Name of Recipient)
(Address / Fax / Phone of Recipient)
(City, State, Zip Code)

Release the following information:

- Admission Note, Consultation Report, Discharge Summary, Pathology Report, Radiology Report / Films / CD, Other, History and physical, Laboratory Reports, Operative Record, Physical Therapy, EKG, ER Record, Physician Orders

Please state the purpose of the requested disclosure of medical information: _____

This authorization will expire in six (6) months unless an appropriate event is documented as the expiration of the authorization. Please specify the event that may warrant the expiration of this authorization below:

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing and addressed to the Privacy Officer of Mountain Lakes Medical Center. I also understand that my revocation will be valid except to the extent that action has already been taken.

_____ (initial) I acknowledge that the information I am authorizing release of may contain documentation of a confidential nature including HIV/AIDS information, substance abuse (drug/alcohol) information, and/or psychiatric/psychological information, and if present, I agree to its release.

_____ (initial) I acknowledge that some of this information mentioned above is protected by Federal Confidentiality rules. The Federal Rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal law.

I understand that Mountain Lakes Medical Center may require a copying fee.

By signing below I acknowledge and affirm the statements in this authorization form.

Signature of Patient or Legal/Authorized Representative *

Date

*If signing as Authorized Representative, please check the appropriate capacity that allows you to authorize disclosure:

- Guardian, Executor, Administrator, Next of Kin, Holder of Health Care Power of Attorney

You will be required to provide evidence of your authority.

- Copies of Court Documents provided and attached to this release, Photo ID, Verification of Signature, Person Known to Me

COMPLETED BY: _____

Date: _____