



AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Please return this Authorization to Release or Obtain Protected Health Information via mail or fax to: SunCrest Home Health Southside – Privacy Office
1039 Ridge Ave. • Atlanta, GA 30315 • Fax Number: 770-212-2311

Patient Name:	Date of Birth:	Last 4 Digits of SSN:
I authorize:		
Name: _____		
Mailing Address: _____		
Telephone Number: _____		Fax Number: _____
<input type="checkbox"/> TO RELEASE Information <u>TO</u> OR <input type="checkbox"/> TO OBTAIN Information <u>FROM</u>		
Name: _____		
Mailing Address: _____		
Telephone Number: _____		Fax Number: _____
Method of Delivery: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Hand Delivery <input type="checkbox"/> Pick Up <input type="checkbox"/> Secure Email (if selected, list email address): _____		

The purpose of this authorization is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

- Further Medical Care Personal Legal Changing Physicians Disability Insurance
 Other: _____

I authorize the release of the following protected health information for the dates of service(s) listed: _____

(Place an "X" in the box(es) that apply to information you want released or to obtain.)

- Entire Medical Record History and Physical Plan of Care Oasis Treatment or Tests MARS/Medications
 Physician Orders Therapy Notes Laboratory Reports Nursing Notes Discharge Summary
 Other: _____

For Social Worker purposes:

- Electric Company Area on Aging Meals on Wheels Homemaker Services Other: _____

Name of Resource Company: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here

If this authorization is for disclosure of genetic information, please explain: _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If this authorization is for genetic information, it is invalid if used for any purpose other than that specified above.
5. 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 and may be re-disclosed.

This authorization shall expire on _____ (date or event)

I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed. I acknowledge that I have read this form. If this authorization is for disclosure of genetic information, it will expire 60 days from the date it is signed.

Signature of Patient/Patient's Representative Date

Print Name of Patient/Patient's Representative Relationship to Patient

Proof of identification should accompany this patient authorization form (See examples below):
-Copy of License -Social Security Card -Power of Attorney -Admission Documentation to Verify Signature -Death Certificate