

W *falany & hulse* WOMEN'S CENTER

10515 Bells Ferry Rd., Bldg. B, Ste. 200
Canton, Georgia 30114
Ph: 770-720-8551 Fax: 770-345-2738

36 Mulberry Street, Suite 6,
East Ellijay, Georgia 30540
Ph: 706-698-6400 Fax: 706-698-6401

Medical Record: _____

Pick up Mail Out Fax

Authorization For Release of Confidential Medical Information

Patient Name: _____ SSN: _____

Date of Birth: _____ Patient Phone Number: _____

Treatment dates to be released: _____

This information is to be released to:

Name: _____ Phone number: _____

Address: _____ Fax number: _____

City, State, Zip: _____

Purpose of Disclosure (check one):

Insurance/Billing Legal Continuing Care

Other Specify _____

The information disclosed may be subject to re-disclosure and will no longer be protected by Falany & Hulse Women's Center Privacy Rules.

Records will be faxed to Health Care Providers for urgent medical care only.

Portions of Record needed (check all that apply):

All Records Most Recent Visit Mammogram / Radiology Report Labs / Pathology

Other Records Specify: _____

I hereby authorize Falany & Hulse Women's Center to disclose / release medical records and / or other information obtained in the course of my diagnosis and / or treatment. I agree to pay copy charges if applicable for Legal, Insurance, and / or personal use. I hereby release Falany & Hulse Women's Center from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information release. I understand that I may revoke this authorization by providing written notice of my intentions. Unless withdrawn, this consent will expire 60 days from the date signed.

This information may include Medical / Surgical, Psychiatric, Substance Abuse, and HIV / AIDS information.

I authorize Falany & Hulse Women's Center to fax this information to the requested Health Care Provider / Individual.

If a request is received without adequate patient authorization it will be returned to the requesting party. Records requests will be processed within 7 to 10 business days from the time which Falany & Hulse Women's Center receives the request. If you need your records expedited please specify the date by which you need them, and the reason for expedition request. Every effort will be made to accommodate expedition requests however we can not guarantee expedition.

Translator's Signature: _____

Patient's Signature

Date

Patient's Representative

Date

Authority to sign on behalf of the patient is authorized by: _____

Witnessed by: _____

Picture ID or the patient's signatures were used to verify identity

Patient has an appointment scheduled for: _____