SOUTHERN ORTHOPAEDICS & SPORTS MEDICINE
3231 Glynn Avenue | Brunswick, GA 31520 | 912.265.9006

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please complete the following information:

Date: _____ Acct#: _____

Patient Name: _____

Address: _____

Phone:_____ Date of Birth: _____/____/_____

The above listed patient authorizes the following healthcare facility to make the following record disclosure:

❑ All records ❑ Billing records ❑ X-ray/radiology records on CD (Disk) $20 Fee

❑ Laboratory/pathology ❑ Physical Therapy Other (specifically) _____

❑ **From Facility:**

Name: _____

Address: _____

Phone: _____

Fax: _____

❑ **Release to:**

Southern Orthopaedics and Sports Medicine, PC
3231 Glynn Avenue, Brunswick, GA 31520
Phone: (912) 265-9006 Fax: (912) 265-7200

❑ **Release From:**

Southern Orthopaedics and Sports Medicine, PC
3231 Glynn Avenue, Brunswick, GA 31520
Phone: (912) 265-9006 Fax: (912) 265-7200

❑ **To Facility / Patient**

Name: _____

Address: _____

Phone: _____

Fax: _____

These records are for services provided on the following date(s): _____

Note: If these records contain any informtion from previous providers or information about HIV/AIDS status, cancer diagnosis, d rug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This authorization shall not be valid for greater than one year from the date of signature.

_____ _____

Signature of patient (or patient's personal representative) Date

OFFICE USE ONLY

Completed By: _____

Date Records picked up / faxed / mailed: _____