COFFEE REGIONAL MEDICAL CENTER

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1ROI

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Social Security #: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Coffee Regional Medical Center Health Information Services Department
   Address: 1101 Ocilla Road Douglas, GA 31533
3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

☐ most recent history and physical	from (date) _____	to (date) _____
☐ most recent discharge summary	from (date) _____	to (date) _____
☐ laboratory results	from (date) _____	to (date) _____
☐ x–ray and imaging services	from (date) _____	to (date) _____
☐ consultation reports	from (date) _____	to (date) _____
☐ entire record	from (date) _____	to (date) _____
☐ Other: _____		
	from (date) _____	to (date) _____

4. **Some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors.**
5. **HIPAA Consent / Privacy Notice:**
   I Understand that Coffee regional Medical Center will use and disclose protected health information about me as a patient or about the patient on whose behalf I am giving this consent to carry out treatment, payment or health care operations and will limit other disclosures as described in the Notice of Privacy Practices ("Notice") of Coffee Regional Medical Center. I Understand that I have the right to receive a paper copy of this notice upon request by calling (912) 384 – 1900, ext. 4549 or by visiting our Web Site www.coffeeregional.org.
6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
7. This information may be disclosed to and used by the following individual or organization:
   _____
   Address: _____
   For the following purpose(s): ☐ Legal Use ☐ Insurance Claim ☐ Personal Use ☐ Continuing care
   ☐ Other (Explain): _____
8. I understand that I have the 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 Services Department. I understand that the revocation will not apply to information that has already been released to this 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 six months.
9. 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 assure 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 redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Coffee Regional Medical Center's Privacy Officer at (912) 383–5619.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signed by Legal Representative, Relationship to Patient Signature of Witness