Dr. Mac Sims

AUTHORIZATION FOR RELEASE OF INFORMATION OR INDIVIDUAL ACCESS TO INFORMATION

I hereby authorize Dr. Mac Sims to: ☐ release ☐ obtain medical information of
Patients full name: _____ DOB: _____ Last 4 of SSN: _____

I request only the following information to be released/obtained:
☐ Entire Record ☐ Operative Reports ☐ Emergency Reports ☐ Pathology Reports ☐ Itemized Billing Statements
☐ Radiology Reports ☐ MRI CD/Reports ☐ Pain Management ☐ History and Physical ☐ X-ray Reports
☐ Other (specify) _____

I hereby authorize Dr. Mac Sims to release any of my Protected Health Information/Medical Records/Appointments information to the below individuals ONLY:

Name: _____ Relationship: _____ Contact Info: _____
Name: _____ Relationship: _____ Contact Info: _____
Name: _____ Relationship: _____ Contact Info: _____

Date(s) of Treatment: _____
Requested from: Physician/Institution/Agency: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither Dr. Mac Sims nor any of its affiliated health care providers can make me sign this Authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allows it. This does not apply to the billing of medical claims. I agree that I have received a signed copy of this Authorization if I choose so.

I understand the I may revoke the Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. I understand that this authorization shall remain valid for one year from the date signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I need to mail, fax, or bring the letter to the address (1622 Madison Avenue, Tifton, GA 31794) or fax number (229-387-8064).

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility the information is being requested from.

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above referenced care. This decision to enter any such conversation is that of the health care provider. However, disclosure that exceeds that scope of this authorization may subject the health care provider to civil liability. This Authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

Note: Records will be mailed/faxed to the above address/number unless otherwise noted below.

Signature of Patient/Legal Guardian/Personal Representative: _____

If someone else signs on behalf of the patient, state relationship: _____

Witness: _____ Date: _____

Note: if the above address is not the patient's, please complete the following:

Patient Address: _____ City: _____ Zip: _____

Initial if a patient will pick up copies at Dr. Mac Sims Office: _____