Authorization for Release of Medical Information

One Per Request

Patient Full Name **(Print)** ________________________ MRN (office use) ________________ DOB ____________

is requesting that the Greenville Health System release health information

(check one) ☐ To or obtain ☐ From the person/company/agency/facility listed below.

Name, Position, or Department: ____

Name of Organization: ____

Address of Organization: ____

Phone number of Organization: ____

The information to be disclosed relates to service dates beginning ____________ and ending ____________

- ❏ Entire Medical Record
- ❏ Demographic Information
- ❏ History & Physical
- ❏ Medical/Surgical History
- ❏ Physician Office Visits
- ❏ Medication List
- ❏ Immunizations
- ❏ Test Results (lab, X-ray, etc.)
- ❏ Other Assessments
- ❏ Discharge Summary
- ❏ Physical Therapy Notes
- ❏ Occupational Health Record
- ❏ Other: (specify) ________________
- ❏ Other: (specify) ________________
- ❏ Other: (specify) ________________

The purpose of the disclosure: *("Request of the Individual" is sufficient for patient-initiated releases)*

- ❏ Request of Individual
- ❏ Referral to Specialist
- ❏ Continuing Care
- ❏ Change of Doctor
- ❏ Insurance
- ❏ Workers' Comp
- ❏ Legal Investigation
- ❏ Other: (specify) ________________

Conditions and Notifications:
This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor/Manager. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the GHS University Medical Group, to GHS, and each practice and entity affiliated with it including GHS Partners in Health.
Note: There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

Signatures:
I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary, and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: ______________________________ Date: ____________

Print Name of Personal Representative: ______________________________

Relationship of Representative to Patient: ______________________________

Released by: ______________________________ Date: ________________
(Department Representative Name)

****Additional Form Required for Each Provider****