THE GEORGIA INSTITUTE FOR PLASTIC SURGERY

feel better about yourself©

Authorization to Disclose Protected Health Information

The undersigned authorizes:

The Georgia Institute For Plastic Surgery

5361 Reynolds Street • Savannah, GA 31405

Ph. (912) 355-8000 • Fax (912) 355-8403

To release my health information as noted below:

Patient Information

Patient FULL Name:		**Other Name(s):**	
Street Address:		**City:**	**State:** **Zip:**
Date of Birth:	**Best Contact Number ( )**	**Doctor:**	

Release Information To:

Name / Facility:			**Attention:**
Address:			**Phone #: ( )**
City:	**State:**	**Zip Code:**	**Fax # : ( )**

↑Email Address For Record Delivery: *Please ensure email address is legible.*↑

Purpose of Request: ❒ Personal ❒ Treatment ❒ Legal ❒ Insurance ❒ Transfer ❒ Other: _____

Information to be Released: *If you fail to specify, a 1 year abstract will be provided*

❒ **Office Notes** ❒ **Labs**

❒ **Operative Notes** ❒ **Diagnostic Reports**

Specify Date(s) of Service: _____

❒ **Entire Chart** ❒ **Photos**

❒ **Other** (please specify) _____

DELIVERY METHOD	❒ Patient Pick-Up	❒ Mail Records on Paper	❒ Fax	❒ Mail Records on CD

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies.

At no time will the cost-based fees exceed GA Law.

I understand I will be responsible for the charges incurred in the release of my protected health information.

Rates are determined by Delivery Method Selected.

****Payment Options: Check/Cash/Credit Card/Money Order****

****No Charge For Records Being Released To Another Healthcare Provider****

_____/_____/20_____ **Date Rec'd by Med Rec Custodian** _____**Initials**

_____/_____/20_____ **Date Reviewed by Physician** _____ **Initials**

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

***** _____ ***(Please Initial)***

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be a condition of signing the authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
   Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
   If I do not specify an expiration date, this authorization will expire in 90 days
4. If the requestor or receiver is Not a Health Plan or Health Care Provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, if I ask for it. I can request a copy of this form after I sign and date it.

STOP ***Please Confirm that you have filled out this form in its Entirety –if the form is Incomplete, or if protected information is not released, we may be unable to fulfill this request*** STOP

Signature: _____ ***Date:*** _____

❖ **For Non-Emancipated Minors under the age of 18, a Parent or Legal Guardian Must Sign Release Form.** **Rev. 2/23**

If patient is unable to sign, a copy of the Legal Documentation for the Patient's Representative must be accompanied with this form.