Northridge Medical Center
Emergency Dept.
70 Medical Center Drive
Commerce, GA 30529
Phone: (706) 335-1400 Fax: (706) 336-8419

Authorization for Release of Information

I hereby authorize Northridge Medical Center and/or _____ to release the following information:

	History & Physical Report		Discharge Summary		Discharge Instructions
	Consultation Report		Operative Note		Radiology Report(s)
	Laboratory Report(s)		Abstract Copy of Entire Chart		Emergency Department Record
	Other – please specify:				

From the medical records of _____
Patient Name

Date of Birth ____/____/____ Social Security Number _____

Hospitalization Dates: _____

Please release information to _____
Person/Organization to which disclosure is being made

_____
Mailing Address City State Zip code

_____ _____
Phone Number Fax Number

The purpose of this disclosure is for/to:

	Continued Medical Care		Settle Insurance Claim
	Keep Family/Significant Other Informed		Assist With Legal Issue
	Other – please specify		

The method of releasing this information is:

	Pick-up		Fax		Mail		Electronic Media File/USB drive

I understand this authorization includes release of medical records which may include information regarding Human Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, venereal disease, and/or other statutory protected disease. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent in writing at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Signature of Patient/Resident/Responsible Party Date Relationship

_____ _____
Printed Name of Patient/Resident/Responsible Party Witness