



Northridge Medical Center
 H.I.M. Department
 70 Medical Center Drive
 Commerce, GA 30529
 Phone: (706)335-1151 Fax: (706)335-0780

Authorization for Release of Information

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

<input type="checkbox"/>	Entire Medical Record	<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	Emergency Department Record
<input type="checkbox"/>	History & Physical Report	<input type="checkbox"/>	Operative Note	<input type="checkbox"/>	Consultation Report
<input type="checkbox"/>	Progress Notes	<input type="checkbox"/>	Physician Orders	<input type="checkbox"/>	Laboratory Report(s)
<input type="checkbox"/>	Radiology Report(s)	<input type="checkbox"/>	Discharge Instructions	<input type="checkbox"/>	EKG
<input type="checkbox"/>	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:

<input type="checkbox"/>	Continued Medical Care	<input type="checkbox"/>	Settle Insurance Claim
<input type="checkbox"/>	Keep Family/Significant Other Informed	<input type="checkbox"/>	Assist With Legal Issue
<input type="checkbox"/>	Other – please specify		

The method of releasing this information is:

<input type="checkbox"/>	Pick-up	<input type="checkbox"/>	Fax	<input type="checkbox"/>	Mail	<input type="checkbox"/>	Electronic Media File
--------------------------	---------	--------------------------	-----	--------------------------	------	--------------------------	-----------------------

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