HIPAA (Authorization for Release of Information)

Savannah Psychiatry

635 Stephenson Avenue, Savannah, GA 31405 Telephone (912) 352-2921 Facsimile (912)352-1038

Patient Name:____DOB:______________________________

I Authorize Savannah Psychiatry to release medical information as indicated below:

Name:_______________________________________ Relationship:_______________________DOB:__________________

Name:_______________________________________ Relationship:_______________________DOB:__________________

Name:_______________________________________ Relationship:_______________________DOB:__________________

INFORMATION TO BE RELEASED: (Check All That Apply)

( ) Entire Record
( ) Lab Results
( ) Dictated Reports (H&P, Progress Notes)
( )Medication Administration Record
( )Billing
( )Other ________________________________

FOR THE PURPOSE OF:

( ) Anything on behalf of the patient
( ) Creating/Changing/Canceling Appointments
( ) View or Correct Demographic Information to include signing in on my behalf
( ) Speaking to Savannah Psychiatry's staff regarding my Protected Health Information including, but not limited to Billing Insurance Information on my behalf
( ) Receive Documents containing my Protected Health Information with an authorization for release of information signed by me
( ) Picking up Prescriptions/Forms and or Medication on my behalf
( )Other: ____

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse or dependency or psychiatric illness.

I understand that the electronic media, and delivery methods such as email and fax, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of Savannah Psychiatry. I agree to assume such risks personally, and to hold Savannah Psychiatry harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing Savannah Psychiatry to transmit or deliver such information electronically.

I understand that this Release of Information will expire within **365 days** from date listed below, unless otherwise indicated below:

( ) Please change the expiration date to last for ____________ days
____________ years
____________ duration of treatment at our office.

I understand this authorization can be revoked at any time according the Savannah Psychiatry privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, and enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Savannah Psychiatry and may potentially be re-disclosed by the party who received these records. Savannah Psychiatry, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I understand that I have the right to:

*Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
*Have a copy of my medical records, or a portion thereof, transmitted to any third party or person I designate.
*Refuse to sign this Authorization.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

Patient Name(print): ______________________________

Patient Signature:______________________________ Date:______________

Patient's Guardian or Capacity: ______________________ Date: ______________

Relationship to Patient: ______________________________

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FOR OFFICE USE ONLY

Received by:	
Date Received:	**Time Received:**
PHI Disclosed To:	
Action(s) Taken:	
Disclosure Media:	( )Hardcopy ( )Memory Stick ( )CD-Rom ( )Email ( )Other(describe)
Disclosure Signature:	