Fax Request to: 912/348-3905

460 Mall Boulevard • Savannah, Georgia 31406

www.ramonramosmd.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of the named individual's health information as described below:
Please read and complete all areas

Patient's Name _____ Date of Birth ____/____/____
(First, Middle, Last)

Address _____ Phone _____

_____

_____

I am requesting medical records to be obtained **FROM:**

Ramon Ramos, MD
460 Mall Blvd
Savannah, Ga 31406

Please send records **TO:**

REASON FOR THE REQUEST: _____

The following information is to be disclosed: *check the box(es) that apply*

- ☐ All medical records
- ☐ Immunization Records
- ☐ Lab Results
- ☐ Daycare Forms
- ☐ X-rays
- ☐ Sports/Camp Forms
- ☐ Other _____

Sensitive Information: I understand that the information in my record may include information relation to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that I may refuse to sign this authorization and it is strictly voluntary. I do not need to sign this form to assure treatment. I also understand that I may inspect and obtain a copy of the information to be used or disclosed for a reasonable fee.

Expiration Date _____ *Unless otherwise revoked, this authorization will expire on this expiration date.*

_____
Signature of Parent or Guardian *(if patient is over 18 years of age, they must sign for themselves)*

_____ _____
Relationship to Patient Date