For Internal Purposes
Medical Record Number: _____

FLOYD HEALTH SYSTEM
MEDICAL INFORMATION RELEASE AUTHORIZATION

THIS AUTHORIZATION CAN ONLY BE HONORED WHEN ALL PORTIONS HAVE BEEN COMPLETED.

Patient Name: _____ Date of Birth: _____ Social Security No.: _____ (Last 4 digits only)

Previous Name (if applicable): _____

Address: _____ Home Telephone: ( )- - _____

Alternate Telephone: ( )- - _____

City: _____ State: _____ Zip Code: _____ E-mail Address: _____

(Name & address of individual / organization who is being asked to release records)

I hereby authorize _____

to release information from the medical records of the above-named patient to: _____

_____

(Name and address of person / organization to whom disclosure is to be made)

Purpose of Disclosure: (A reason must be provided)

☐ At the request of the individual signing this authorization ☐ Other (Specify): _____

For the following treatment dates:

☐ All dates of treatment ☐ For dates of treatment from _____ to _____

Specific description of information to be disclosed:

☐ Entire Medical Record* (Includes all items in the chart for the dates specified)

☐ Abstract of Record* (Includes the History & Physical, Operative, Consultation, Diagnostic test results, and Discharge Summary)

☐ Cardiac Cath Report	☐ Gastrointestinal (GI) Lab Report	☐ Pathology Report
☐ Discharge Summary	☐ Laboratory Report	☐ Radiology Report
☐ Emergency Room Record	☐ Medication Record	☐ Operative Report
☐ EKG Report	☐ Other (Specify): _____	

☐ *You must check this box if you are also requesting Billing Records*

Method of Receipt of Information: ☐ PAPER COPY

☐ Electronic Copy via e-mail portal *(Provided by HIM ROI Dept only)*

☐ CD/Film of radiology images *(Provided by Radiology Dept only)*

Unless I request in writing otherwise, this authorization will expire on_____. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date which it was signed. I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization in writing at any time by sending the revocation to the health care provider indicated above, except to the extent that action has already been taken in reliance on this authorization. Aside from this, I understand that upon expiration of the authorization, no further disclosure of the information may be made. I understand that a health care provider may decline to treat me if I refuse to sign this authorization only when the treatment is for the sole purpose of creating health information for disclosure to a third party. **I further understand that the records/information to be released may contain or consist of information related to the following: contagious diseases (HIV/AIDS, tuberculosis, hepatitis, etc.); psychiatric treatment or psychotherapy notes; and drug/alcohol abuse (42 CFR Part 2) . I hereby waive any privilege concerning such information for the purposes of releasing it to the party or parties authorized above.**

Signature of Patient or Person Authorized to Act on Patient's Behalf:

_____

Relationship to Patient: _____ Date AND Time: _____

For questions regarding Release of Information call: **Floyd Medical Center and Polk Medical Center 706-509-6185**
Floyd Cherokee Medical Center 256-927-5531

You may mail your completed "MEDICAL INFORMATION RELEASE AUTHORIZATION" to:

Floyd Medical Center
Attention: Release of Information
304 Turner McCall Blvd
Rome, GA 30165

Floyd Cherokee Medical Center
Attention: Release of Information
400 Northwood Drive
Centre, AL 35960

Patient Identification