

BLUE Med Center

Authorization for Release of Protected Health Information (PHI)

HIPAA-Compliant – State of Georgia

Patient Information

- **Legal Name (First, Middle, Last):** _____
 - **Name Used During Treatment (if different):** _____
 - **Date of Birth:** ___ / ___ / _____
-

Patient Contact Information

- **Mailing Address:**
Street: _____
City: _____ State: _____ ZIP: _____
 - **Telephone Number:** _____
 - **Email Address:** _____
-

Authorization to Release Medical Records

I hereby authorize **BLUE Med Center** to disclose my protected health information as described below.

Recipient of Records (check one)

- Send records directly to me (patient)**
- Send records to another person or healthcare provider (complete below):**
 - **Name of Individual or Practice:** _____
 - **Attention (if applicable):** _____

Mailing Address:

- Street: _____
City: _____ State: _____ ZIP: _____
- **Telephone Number:** _____
 - **Fax Number (if applicable):** _____
 - **Email Address (if applicable):** _____
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Description of Information to Be Released

- All medical records maintained by BLUE Med Center
- Specific information only (check all that apply):
- Office visit notes
- Lab results
- Other (please specify): _____

Date Range of Records (if applicable):

From ___ / ___ / _____ to ___ / ___ / _____

Purpose of Disclosure (check one)

- At the request of the individual
- Continuity of care
- Insurance or payment

- Legal
 - Other: _____
-

Expiration of Authorization

This authorization will expire on (choose one):

- ___ / ___ / ____ (specific expiration date)
 - 90 days from the date of signature**
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Patient Rights and Acknowledgment (Georgia & HIPAA Required)

- I understand that I have the **right to revoke this authorization** at any time by submitting a written request to BLUE Med Center, except to the extent that action has already been taken in reliance on this authorization.
- I understand that treatment, payment, enrollment, or eligibility for benefits **will not be conditioned** on whether I sign this authorization.
- I understand that information disclosed pursuant to this authorization **may be subject to redisclosure** by the recipient and may no longer be protected under HIPAA privacy regulations.
- I understand that **Georgia law and federal law** protect the privacy of my medical information.

If this authorization includes records relating to **HIV/AIDS, mental health treatment, substance use disorder treatment, genetic testing, or other specially protected information**, I specifically authorize release of such information as permitted by law.

Signature and Authority

I certify that I am either the patient or the patient’s legally authorized representative and that I have the authority to sign this authorization.

Signature of Patient or Authorized Representative
(original signature required):

Printed Name: _____

Relationship to Patient (if not patient): _____

Date: ___ / ___ / ____

Submission Instructions

Please mail the completed form with **original signature** to:

BLUE Med Center
Medical Records Department
925B No. 301 Peachtree Street NE
Atlanta, GA 30309
