Authorization to

Release Protected Health Information

I, ____ ____________________________
(Patient's Full Name) (Date of Birth)

Hereby request and authorize: ____

to release the following information for continuation of care to:

HABERSHAM SURGICAL SERVICES

638 Historic Hwy Old 441 N Suite B Demorest, GA 30535

P: 706-754-8339 F: 706-754-8460

Please Circle All That Apply:

All Records History & Physical Clinic Notes Abstract/Summary Discharge Summary

Surgical Reports Pathology Reports Emergency Notes Radiology Other:

____

Delivery Method Preferred: Fax Mail Other: ____

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. ________ (Please Initial)

I understand that: I may refuse to sign this authorization and that is it strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ___________. If I do not specify expiration this authorization will expire in 365 days. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal Privacy Regulations and may be disclosed.

Signature: ____ Date: ________________________