**TIFT REGIONAL HEALTH SYSTEM, INC.**
TIFT REGIONAL MEDICAL CENTER/
SOUTHWELL MEDICAL, A CAMPUS OF TIFT REGIONAL MEDICAL CENTER

AUTHORIZATION TO RELEASE / OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____ Medical Record Number: _____
Date of Birth: _____ Last 4 digits of SS number: _____

1. Facility(ies): I authorize representatives from the following Tift Regional Health System, Inc. ("TRHS") facility(ies) to disclose the health information as directed below:
   - ☐ Tift Regional Medical Center
   - ☐ Southwell Health and Rehabilitation
   - ☐ Southwell Medical, a campus of TRMC
   - ☐ Southwell Medical Rural Health Clinic; Please list _____
   - ☐ Other: _____

2. Description of health information to be disclosed: (check all that apply)

| | |
|---|---|
| ☐ problem list | ☐ most recent discharge summary |
| ☐ medication list | ☐ most recent history and physical |
| ☐ physician orders | ☐ physician progress notes |
| ☐ laboratory results | from date _____ to date _____ |
| ☐ x-ray / imaging reports | from date _____ to date _____ |
| ☐ x-ray films | from date _____ to date _____ |
| ☐ consultation reports | from (doctor's name) _____ |
| ☐ entire record | from date _____ to date _____ |
| ☐ billing records | from date _____ to date _____ |
| ☐ other_____ | |

3. I understand that these records may contain information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug abuse, alcoholism, sickle cell anemia, and behavior or mental health services.

4. This information may be disclosed to and used by the following individual or organization:

Name: _____ Phone Number: _____

Address: _____
Via: ☐ Paper ☐ CD ☐ Electronic Delivery (include e-mail address) _____

5. For the following purpose: (check all that apply)

☐ Legal Issue ☐ Insurance Claim ☐ Personal Use ☐ Certified Copy
☐ Continuing Care ☐ Other (explain): _____

6. I understand that this Authorization, except for action already taken, may be revoked by me at any time. I understand that if I revoke this Authorization, I must do so in writing and present my written revocation to the Health Information Management Department, PO Box 2560, Tifton, GA 31793, 229-353-6120. I understand that this Authorization will expire on _____ (insert expiration date or event). If I do not specify an expiration date or event, this Authorization will expire ninety (90) days from the date on which I signed this Authorization.

7. I understand that TRHS will not condition treatment, payment, enrollment, or eligibility for benefits concerning my health care on whether I sign or refuse to sign this authorization.

8. I understand that authorizing the disclosure of this health information is voluntary and that disclosure of such information carries with it the potential for unauthorized re-disclosure.

| Signature of Patient or Legal Representative | Date Signed | Time |
|---|---|---|

| Print Name | Relationship to Patient |
|---|---|

| Signature of Witness | Date | Time |
|---|---|---|