

SOUTHWELL AMBULATORY, INC.

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Phone number: _____ Last 4 digits Social Security # _____

1. I hereby authorize the use or disclosure of the above named individual's health information as described below. _____ is authorized to make the disclosure of the following information as indicated: (check all that apply)

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

2. I understand 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.

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

Name: **Southwell OB/GYN** Phone No: **229-262-6810**

Address: **814 Northwood Park Drive, Valdosta, GA 31602**

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

- Legal Issue
- Continuing Care
- Insurance Claim
- Other (explain): _____
- Personal Use

Need records certified Yes No

5. 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. Unless otherwise revoked, this authorization will expire 90 days from today's date and must post date any date of service being requested.

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

7. 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