Wildwood
LIFESTYLE CENTER
Medical Records Department
435 Lifestyle Lane • Wildwood, Georgia 30757-0129 • Phone (706) 820-1493 ext 1008 • Fax (706) 820-1474
Email: clinic@wildwoodhealth.org

Authorization for Release of Medical Information

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance and Portability and Accountability Act (HIPAA) privacy regulations.

Patient's Name	Telephone Number	Date of Birth

I authorize the use and disclosure of health information about me as described below:

Facility authorized to release my health information	Telephone Number	Fax Number
Wildwood Lifestyle Center	(706) 820-1493	(706) 820-1474
Facility authorized to receive my health information	Telephone Number	Fax Number

Health information that may be used/disclosed is limited to the following: **Provider's Notes, Labs & Testing for the last 3 visits.**

Health information to be released to the above-named entity is to be used/disclosed for the following purpose: **Treatment Consultation**

"Health information" identifies you (the patient) by name and includes other demographic information about you. "Health information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.
I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable diseases including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or making copies thereof in accordance with the policies of this facility.

☑ **Yes** ☐ **No** If applicable, I agree to release of my medical or billing records containing the **sensitive information** listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature below (except as indicated below). I understand that I have the right to revoke this authorization at any time in writing, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with HIPAA privacy regulations.

_____ _____
Patient or Authorized Personal Representative's Signature Date

_____
If person signing above is Personal Representative, then Relationship to Patient / Authority to Act on Patient's Behalf

_____ _____
Witness Signature Date