Northridge Medical Center
H.I.M. Department
70 Medical Center Drive
Commerce, GA 30529
Phone: (706)335-1151 Fax: (706)335-0780

Authorization for Release of Information

I hereby authorize Northridge Medical Center and/or _____ to release the following information:

☐	Entire Medical Record	☐	Discharge Summary	☐	Emergency Department Record
☐	History & Physical Report	☐	Operative Note	☐	Consultation Report
☐	Progress Notes	☐	Physician Orders	☐	Laboratory Report(s)
☐	Radiology Report(s)	☐	Discharge Instructions	☐	EKG
☐	Other – please specify				

From the medical records of _____
Patient Name

Date of Birth ____/____/____ Social Security Number _____

Hospitalization Dates: _____

Please release information to _____
Person/Organization to which disclosure is being made

_____
Mailing Address City State Zip code

_____ _____
Phone Number Fax Number

The purpose of this disclosure is for/to:

☐	Continued Medical Care	☐	Settle Insurance Claim
☐	Keep Family/Significant Other Informed	☐	Assist With Legal Issue
☐	Other – please specify		

The method of releasing this information is:

☐	Pick-up	☐	Fax	☐	Mail	☐	Electronic Media File

I understand this authorization includes release of medical records which may include information regarding Human Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, venereal disease, and/or other statutory protected disease. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent in writing at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Signature of Patient/Resident/Responsible Party Date Relationship

_____ _____
Printed Name of Patient/Resident/Responsible Party Witness