LENOX MEDICAL CLINIC

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Authorization for Release of Medical Records

CONDITIONAL DOCUMENT — Completed Only When Records Are Requested IMPORTANT: You are not required to sign this form to receive treatment at this office.

PATIENT INFORMATION

Patient full legal name : _____ Date of Birth: _____ SSN Last 4 Digits: _____

Maiden Name (if applicable): _____

Current Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

AUTHORIZATION TO RELEASE RECORDS (Please initial next to each applicable authorization)

Initial: **TO PROVIDE RECORDS TO LENOX MEDICAL CLINIC**

_____ Authorize release of my records FROM the following provider to Lenox Medical Clinic:

Provider / Organization Name: _____

Address: _____ Phone: _____ Fax: _____

Initial: **TO RELEASE COPIES OF MY RECORDS TO A THIRD PARTY**

_____ Authorize Lenox Medical Clinic to release copies of my records TO:

Recipient Name / Organization: _____

Address: _____ Phone: _____ Fax: _____

Initial: **TO PERMIT REVIEW OF MY RECORDS**

_____ Authorize the following person to review my records in person:

Name: _____ Relationship: _____

DATE RANGE OF RECORDS REQUESTED

This authorization applies to records from: From: _____ To: _____ ☐All dates on file

PURPOSE OF DISCLOSURE

☐At the request of the patient / personal use

☐Continuity of care / treatment by another provider

☐Legal or insurance purposes

☐Other (please describe): _____

RECORDS TO BE RELEASED

☐Entire Medical Record ☐History and Physical Reports ☐Emergency Records

☐Discharge Summary ☐Laboratory / Pathology Reports ☐Radiology Reports

☐Medication Records ☐EKG / ECG Reports ☐Financial / Billing Records

☐Other (specify): _____

SENSITIVE / SPECIALLY PROTECTED RECORDS (Optional — Initial to Include)

Certain categories of health information are protected by additional federal and state privacy laws. These records are **NOT included** in the release above unless you specifically authorize their disclosure by initialling below. You are not required to authorize release of any of these categories.

Initial: _____ ☐Mental health treatment records (other than psychotherapy process notes)

Initial: _____ ☐Alcohol or substance use disorder treatment records

Initial: _____ ☐HIV / AIDS testing, diagnosis, or treatment information

Initial: _____ ☐Sexually transmitted disease (STD / STI) information

Initial: _____ ☐Genetic testing information

Note: Psychotherapy process notes (detailed session notes kept by a therapist or psychiatrist) require a separate written authorization and are not released under this form.

IMPORTANT INFORMATION ABOUT YOUR AUTHORIZATION

Right to Revoke: You may revoke this authorization at any time by submitting a written revocation to our office. Revocation will not apply to disclosures already made in reliance on this authorization.

Re-Disclosure: Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations once released.

No Conditioning of Treatment: Lenox Medical Clinic will not refuse to treat you based on your decision to sign or not sign this authorization, except in limited circumstances permitted by law.

Expiration: This authorization is valid for 360 days from the date of signing, unless a different expiration date is written here: _____

RECORD COPY FEES

Lenox Medical Clinic does not charge patients for copies of their own medical records. Record copy fees may apply when records are requested by an attorney or legal representative, consistent with applicable Georgia law.

I certify that I have read and understand this Authorization for Release of Medical Records and am authorizing the release of the specific records described above for the stated purpose.

_____ _____ _____

Signature of Patient or Authorized Representative *Printed Name* *Date*

_____ _____

Relationship to Patient (if not patient): *Reason patient unable to sign (if applicable):*