Brookwood Family Medicine

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PATIENT INFORMATION:

Patient Name:_____ DOB:____/_____/_____

Address:_____ Age/Sex:_____years old / ( )Male ( )Female

_____ Phone:_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Effective Date:_____

Medical Records were requested by the patient or legal entity referencing said patient following HIPAA guidelines to be released to designated person(s)/organization documented below. Records produced & maintained by Brookwood Family Medicine will be provided with applicable cost specified below and per Georgia State Copy Law, Section 2: Code Section: 31-33-3. Upon transfer of medical records Brookwood Family Medicine holds no liability on the use or loss of those records obtained by the patient or designated entity and is solely the responsibility of the patient or legal entity to keep his/her records private and secure in accordance to HIPAA regulations.

Reasonable Cost of Copying **(FOR OFFICE USE ONLY :)**

Pages 01-20	_____#pg	@ 0.97 cents ea.	=	$_____
Pages 21-100	_____#pg	@ 0.83 cents ea.	=	$_____
Pages 101-up	_____#pg	@ 0.66 cents ea.	=	$_____
Search, retrieval & administrative costs		@ $25.88	=	$_____
Certification fee (if applicable)		@ $9.70	=	$_____
Postage		@ $_____	=	$_____
		Total Cost	=	**$**_____

Per office Policy 1st Copy of Patient Records are provided gratis with fees waived. Any future/additional requests for medical records will require copying fees to be paid before records will be prepared subsequent times.

1. Patient Release Authorization:

I, the patient/legal guardian, hereby authorize Brookwood Family Medicine to release information contained in the medical records of the above named patient. This release applies to all records created and maintained by Brookwood Family Medicine on said patient including records for physical and / or mental illness, treatment of chemical dependency and / or alcohol abuse, testing or treatment of any communicable or infectious disease such as Acquired Immunodeficiency Syndrome (AIDS); Human Immunodeficiency Virus (HIV); Acquired Immunodeficiency Syndrome Related Complex (ARC); Venereal Diseases, Tuberculosis or Hepatitis unless otherwise objected to by above named patient / legal guardian.

2. Authorized Person(s)/Designee to Receive Records: ☐ Patient/Legal Guardian *(send to address aforementioned above)*

☐ New Provider / Medical Practice *(complete below)*

Practice Name / Provider Name:_____

Address:_____ **Phone:** (____) ____-____

City, State, ZIP:_____ **Fax:** (____) ____-____

3. Format of records being released: Digital copy of chart in .pdf format will be prepared and mailed to designee.

I authorize the above facility to send the required medical information by fax or mail. This authorization will expire 1 year from signed date unless otherwise specified or cancelled by myself (the patient)/Legal Guardian.

_____ _____

DATE **Signature of Patient or Legal Guardian of Patient**

_____ _____

DATE **Signature of Witness**

Note: If above signature is that of the legal guardian or estate representative, a copy of a court order must be attached. If patient is deceased, administrator of patient's estate or nearest relative may sign. If a minor, parent or legal guardian must sign. This consent is subject to patient cancellation at any time unless Brookwood Family Medicine has already taken action based on this authorization.