REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name:	Date of Birth
Social Security Number:	Phone Number (C) (H)
Contact Person (If other than Patient)	Contact's Phone:

Medical Information

	Complete Medical Record		Demographic/Visit History
	Discharge/Transfer Summary		X-Ray
	Lab		Abstract of Medical Record
	History & Physical Exam		EKG
	Pathology Reports		Operative Reports
	Consultation Report		Other:

I authorize Symponia Hospice to obtain my medical records (including medical information related to the diagnosis or treatment of my medical conditions) as specified above.

REASON FOR REQUEST: ________________________________

DELIVERY MODE

_______ Call ___________ when photocopies are available for pick-up

_______ Please FAX records to: _____________

_______ Please mail records to: _____________

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Symponia Hospice, LLC. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect, or receive copies of the information to be used or disclosed, as provided in CFR 164524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at 770-485-9186.

Patient/Legal Representative Signature____

Legal Relationship: ____Date: ______________

Created:
Updated: