Medical Records Numb	er:
	(for internal purposes)



Health Professions Associates

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:	Last 4 digits of SSN:		
Address:	Date of Birth:		
City/State/Zip:	Phone #:	_	
	ic disclosure and AU Health VIP access)		
AU Health Professions Associates Health Clinic			
Clinic for Prosthetic Restoration Loutherized the facility indicated above to use or disalog	987 Saint Sebastian Way, EC 1500, Augusta, GA 30912 Phone: 706.721.1225 before November 1, 2018 706-721-2621 after November 1, 2018 e the above named individual's health information as described		
below, concerning the period from			
☐ Medical Information, as specified: ☐ Standard Document Set (Discharge Summary, F) ☐ Other (specify): ☐ Entire Medical Record (justification required):	istory and Physical, Progress Notes, Test Results, Consults)		
☐ Psychiatric/Psychological Information ☐ Drug/Alcoh This information may be disclosed to and used by the fo Name:			
	City/State/Zip:		
Special instructions:		_	
information management department. I understand that the in response to this authorization. I understand that the revoc my insurer with the right to contest a claim under my policy	I understand that I have a right to revoke this authorization at any to so in writing and present my written revocation to the health revocation will not apply to information that has already been released ation will not apply to my insurance company when the law provides. Unless otherwise revoked, this authorization will expire on the If 1 fair zation will expire in 90 days.	d	
sign this form in order to ensure treatment. I understand that in the Standard Access of an Individual to Protected He	formation is voluntary. I can refuse to sign this authorization. I need in may inspect or copy the information to be used or disclosed, as provided the Information (CFR 164.524). I understand that any disclosure disclosure and the information may not be protected by fede	led of	
Signature of Patient or Legal Representative	Date Time		
If Signed by Legal Representative, Relationship to Patient	Signature of Witness		