RESURGIA Health Solutions

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO RESURGIA

I, ______________________________hereby give my permission for Resurgia Health Solutions ("Resurgia") to release my medical information as outlined below to the facility/provider named below, for the purpose(s) listed below. I understand that Resurgia will not be responsible for the ongoing use of my information by the receiving entity.

Should you have any questions, please contact Resurgia Health Solutions at (404) 445-5304.

RECEIVING ENTITY AND PURPOSE

Receiving Entity:	
Purpose:	
Fax #:	

PATIENT INFORMATION

Name:	
Date of Birth:	

Information to be Released:

- [ ] All Medical Records
- [ ] All Medical Billing Records
- [ ] X-Ray and imaging reports

Dates of Treatment:

- [ ] All Dates
- [ ] Specific Dates: __________ to __________

Other and Exclusions:

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. 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. To revoke an authorization, I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

Patient	Patient Representative and/or Caregiver (if applicable)
Signature:________________________	Signature:________________________
Print Name:________________________	Print Name:________________________
Date:________________________	Date:________________________