

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO RESURGIA

I, _____ hereby give my permission for my current doctor or hospital, _____ to release my medical records to Resurgia Health Solutions so they can better understand my medical history and treat my current conditions.

Please fax my medical records to Resurgia Health Solutions at (404) 445-5173.
Should you have any questions, please contact Resurgia Health Solutions at (404) 445-5304.

Patient Information

Name:	
Date of Birth:	
Social Security Number:	

Information to be Released:

<input type="checkbox"/>	All Medical Records
<input type="checkbox"/>	All Medical Billing Records
<input type="checkbox"/>	X-Ray and imaging reports

Dates of Treatment:

<input type="checkbox"/>	All Dates
<input type="checkbox"/>	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

Signature: _____

Print Name: _____

Date: _____

Patient Representative and/or Caregiver (if applicable)

Signature: _____

Print Name: _____

Date: _____