ATLANTIC RADIOLOGY
Pooler Imaging Center

# Authorization To Release Medical Information

I authorize the named healthcare provider to release the information or records specified upon request in person or by mail to the address specified at the time of the request.

**Provider:**

**Pooler Imaging Center**
**136 Traders Way**
**Pooler, Georgia 31322**

Patient:
SSN #:
DOB:

**Records Authorized To Be Released:**

- ☐ Admission history and physical
- ☐ Discharge summary
- ☐ Complete hospital chart
- ☐ Office notes
- ☐ Outpatient records
- ☐ Psychiatric and other mental health records
- ☐ Records relating to drug and alcohol abuse (must specify the extent or nature of the records to be released)
- ☐ Medical administration logs, dietary logs, staff contact or service logs, and other records that may be part of my individual medical record, but which contain information relating to me). These records should be redacted to protect information pertaining to other patients.
- ☐ Lab reports
- ☐ Radiological Images
- ☐ Consultation notes or reports
- ☐ Complaints or grievances filed, with respected dispositions
- ☐ Other (specify)

Extent or nature of records to be released:

**This information will be used for the purpose of:**

- Investigating an allegation of abuse
- Providing advocacy services
- Verifying my eligibility for services offered
- Legal representation
- Other activities at the request of the individual

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the healthcare provider or to the facility, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

**I also understand that:**

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original authorization.

Patient or Representative: _____ Date: _____

Name of Representative (print): _____

Relationship to Patient: _____