



**RESURGENS CENTRALIZED MEDICAL RECORDS**  
270 Chastain Road, Kennesaw, GA 30144

**Telephone: 678-594-6100 Fax: 678-459-3166**

Medical Record No. \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

<b>PATIENT IDENTIFICATION</b>	Name: _____ Date of Birth: _____ S.S.# (last four digits only): _____ Maiden/Other names known by: _____
<b>RELEASE RECORDS TO:</b> (Person or Place records should be sent)	Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
<b>RECORDS REQUESTED</b>	<input type="checkbox"/> Medical records <input type="checkbox"/> Films <input type="checkbox"/> Billing statement <input type="checkbox"/> Other: _____ Dates to be included (dates seen or time frame: From: _____ To: _____
<b>PURPOSE OF RELEASE</b>	<input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of the patient <input type="checkbox"/> Other, Please Explain: _____
<p>I understand that my medical record may also include information on diagnosis/treatment related to <b>psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status.</b></p> <p>I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.</p> <p><b>PLEASE INITIAL THE STATEMENT THAT APPLIES (You must initial one)</b></p> <p>I do _____ do not _____ authorize this information to be released.  <b>Limitations, if any:</b> _____</p>	
<b>TIME LIMIT</b>	I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization has no expiration date.

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed Name (if not same as patient): \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_

**THERE WILL BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS THE COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY**

**PLEASE NOTE:**

**When your Medical information is released pursuant to a valid authorization the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.**

ID provided: _____ Date: _____ Comments: _____
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Processed by: _____ Date: _____ Comments: _____
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**How to REVOKE your Authorization for Release of Medical Information**

You have the right to revoke your Authorization for Release of Medical Information. To do so you must send us a written letter revoking your authorization. The letter should be mailed to the following address:

**Resurgens, P.C.  
Medical Information Services- Release of Information  
5671 Peachtree Dunwoody Road, Suite 700  
Atlanta, GA 30342**

If you do not wish to write a letter you may fill out the following form and mail it to the address above.

**Exceptions: This authorization may be revoked except to the extent that:**

1. Resurgens has taken action in reliance thereon: or
2. The authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

**REVOCATION OF AUTHORIZATION**

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, wish to revoke my Authorization for the Release of Medical Information to: \_\_\_\_\_

(Person or place records should **not** be sent)

I also realize in the event that these records have *already* been released by valid authorization that these records cannot be retracted.

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name (if not signed by the patient): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## **INFORMATION FOR PATIENTS:**

**Resurgens is happy to provide your records to you or others upon your request with appropriate authorization and, when required, legal documentation. Due to the large volume of requests received, processing is performed by an outside vendor.**

## **THINGS YOU SHOULD KNOW:**

- **Requests are processed as received. This includes records being sent to a subsequent treating physician or other healthcare provider upon transfer of care or referral. On occasion, records needed for immediate patient care will be handled expeditiously on a case by case basis and provider to provider.**
- **Since records processing is done off-site, patients will no longer be able to pick up records in person except in case of emergency. If your physician needs specific test results or notes, the request should be made directly to the Resurgens physician.**
- **In cases where someone other than the patient executes the authorization, documentation may be required to support the disclosure of personal health information as required by state and federal law.**
- **A reasonable copying fee will be charged by the vendor for processing the request.**
- **Please be sure to complete the authorization thoroughly so that you receive the records you requested (i.e. specific dates of treatment, all records, radiographic studies only, etc.) and to assure that the authorization is HIPAA compliant. Failure to completely fill out the Authorization may result in a delay in processing the request.**
- **If you have any questions, please call the number on the top of the form for assistance.**
- **In most cases, records are processed within 7 days. However, you should be aware that federal and state law allows healthcare providers 30 days to respond to written requests for records that are maintained on site and 60 days for records in storage.**