Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to Phoebe Bariatrics at Phoebe Sumter Medical Center.

Patient Name:_____Date of Birth:_____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Record
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (please specify below)

_____

_____

Release my protected health information to the following physician/facility:

Phoebe Bariatrics
Phoebe Sumter Medical Center
126 Highway 280 West
Americus, Georgia 31719
Ph. 229-931-1152
Fax. 229-931-4938

The purpose or need for information: To continue medical care/treatment.

This consent will expire (90) days after the day below or sooner at my election.

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric disorders, or HIV infection.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

Date:_____ **Signature_____**

Printed Name:_____