

Authorization to Disclose Protected Health Information
The undersigned authorizes:
Savannah Neurology Associates
6602 Waters Avenue, Building C, Savannah GA
(P) 912-354-7676 (F) 912-354-7181
to release my health information as noted below:

Patient Information	
Patient Full Name:	Other Names?
Patient Address:	Date of Birth:
City: State: Zip:	Phone #:
Release Information To	
Email address for record delivery: Please ensure email address is legible!	
If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may	
be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.	
Name/Facility:	Attention:
Address:	Phone:
City: State: Zip:	Fax #:
Purpose of Request: Personal TreatmentLega	alInsuranceTransferOther:
Information to be Released  If you fail to specify, a 1-year abstract will be provided.	
Please release a <b>1-year abstract</b> of my records (includes	(Please pick ONE delivery option)
most recent notes, labs, procedures & testing)	
Please release a <b>2-year abstract</b> of my records (office	[ ] Send by Email [ ] Fax to Doctor [ ] Records on Paper
notes, labs, procedures & testing, up to 2 years)	[ ] Records on CD
Date Range::	Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to
□ Progress Notes □ Radiology Reports □ Labs	charge a reasonable cost-based fee for producing and mailing
☐ Operative Reports ☐ Injections ☐ Physical Therapy	the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the
Other:	cost-based fees exceed Georgia State law
Radiology Disc	Statute: HIPAA 45 CFR, 164.524
Authorization to Release Protected Health Information	
I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse,	
psychiatric, HIV testing, HIV results, or AIDS information.	*(Please Initial)
I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment,	
enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization	
at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. <b>Unless</b>	
otherwise revoked, this authorization will expire on the following date, event or condition: If I do not	
specify expiration this authorization will expire in 90 days. If the requestor or receiver is not a health plan or health care	
provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I	
understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask	
for it. I can request a copy of this form after I sign and date it.	
Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.	
Signature*:	Date:

<sup>\*</sup> For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.