Consent And Authorization For Release Of Patient Health Information

I, _____, born _____ consent to and authorize

_____

(Name of Facility)

to furnish to : **McKinney Medical Center, Inc.**
218 Quarterman Street
Waycross, GA 31501
912-287-9140 (T)
912-287-1059 (F)

the following medical records and information:

_____

(specify all records or records by the service date or period)

except those relating to care and treatment for mental health conditions, drug or alcohol abuse, or HIV testing, infection status, or care and treatment of AIDS, or genetic testing.
Including the following: Please initial beside all four (4)

_____ Relating to care and treatment for mental health conditions
_____ Relating to care and treatment for drug and alcohol abuse
_____ Relating to HIV testing, infection status, or care and treatment of AIDS
_____ Relating to genetic testing

For the purpose of

_____

(Reason for disclosure – change of care, referral visit, insurance update, etc.)

I understand this consent and authorization may be revoked at any time except to the extent already acted upon. This authorization expires within one year from the signature unless written notification is received prior to one year.

A copy of this consent shall be considered as effective and valid as the original.

_____

Signature of Patient *Date*

_____

Witness *Date*

The information disclosed to you may be from records protected by Federal confidentiality rules. This form serves as a general consent and authorization for the release of medical records or other information from this facility.