Cognitive Aging Research and Education Center

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORD INFORMATION

PATIENT INFORMATION

Name: _____ Phone #: _____ DOB:_____

Address:_____

UGA Cognitive Aging Research and Education (CARE) Center
102 Spear Rd., Athens, GA 30602
Fax: 706-583-0109 **| Phone:** 706-542-2539

The University of Georgia (UGA) Cognitive Aging Research and Education (CARE) Center is hereby authorized to receive protected health information **FROM** the following provider(s) or entity **AND** to release protected health information generated by its clinicians **TO** the following provider(s) or entity:

Name: _____ Phone: _____

Address: _____ Fax: _____

The following protected health information regarding the patient may be released (please check ONE of the following boxes):

☐ Complete Medical Record (including labs and radiology)
☐ Abstract of Medical Record (provider-dictated reports & diagnostic reports) **ONLY**
☐ **ONLY** specific types of protected health information (specify here): _____

The purpose of the requested disclosure is: medical/neuropsychological evaluation and/or continuing care.

This authorization for the release of protected health information shall remain in effect until the earlier of any of the following dates:

(a) The date I revoke this authorization in writing; **OR**
(b) Five (5) years from the date on which I signed this authorization

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that my/the patient's treatment at the CARE Center will not be affected if I refuse to sign this authorization.

I understand the information in my health record may include information relating to pregnancy, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health history/services/diagnosis/testing, and treatment for alcohol and drug abuse.

I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage.

NOTE: Please read **BOTH PAGES** of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient **OR** (ii) the patient is alive and you are legally authorized to make their healthcare decisions, including the release of medical records.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____	_____
Signature of Patient (or Legal Representative)	Date
_____	_____
Name of Legal Representative	Relationship to patient (if Legal Representative)