HORIZON BEHAVIORAL HEALTH
Hopeful, Helpful, Healing

508 N Main St, STE A, Hinesville GA 31313
595 Towne Park Dr W, STE 200, Rincon GA 31326
1121 Cornell Ave, Savannah GA 31406
10200 Ford Ave, Ste 103, Richmond Hill GA 31324
Phone: (912) 785.2100 Fax: (912) 368.3868

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print patient's full name) Date of Birth

_____ _____
(Street address) Social Security Number

_____
(City, state, zip code)

I, _____, hereby authorize **HORIZON BEHAVIORAL HEALTH, PC, with principal offices located at 508 N MAIN ST, STE A, HINESVILLE GA 31313, PHONE: 912-785-2100 FAX:912-368-3868** To include all locations and all providers unless noted below under other)

To release the following information to:

_____
(Name of provider/facility)

_____
(Street address)

_____
(City, state, zip code)

_____
(Phone #) (Fax #)

_____Discharge Summary _____ History & Physical _____ Laboratory Results _____ Entire Record

_____ Other: _____

Purpose of disclosure: _____ Personal _____ Continuing Care _____ Insurance
_____ Workers Comp _____ Attorney _____ Other: _____

If this authorization is for release of medical records, I understand that I am giving my permission to release copies of information in my medical records that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing, or treatment of sexually transmitted diseases unless indicated in the following instructions:_____

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of execution. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that there is a retrieval fee of $25.88 per record as well as a per-page fee of $.97 (pp 1-20), $.83 (pp 21-100), $.66 (over 100). I understand that fees are waived when medical records are requested by other health care providers/agencies/facilities for continuing care. All other requests are charged as state and federal laws allow.

_____ _____
Signature of Patient or Guardian Date

_____ _____
ardian Name Relationship to Patient