SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

To Whom It May Concern:

Please fill out the enclosed Authorization for Release of Information.

The release form must be completed, signed, dated, and time entered. We ask that you specify what components of your medical records you wish to obtain/release. Please fill out ALL areas on the form. **Charges will apply for a complete copy of medical records.** Often, the discharge summary, psychiatric evaluation and history and physical contain relevant information that may suit your needs.

Additional information

Please make sure you send a Copy of your Photo ID or Passport along with Release of Information form. Please attach any Power of Attorney paperwork or any legal documentation.

If an individual other than the patient is picking up the records, then that individual must have an original signed authorization letter from the patient along with a photo ID.

Please allow up to **thirty calendar** days for your request to be processed. If you indicated the option to pick-up on your release form, you will be contacted by the Release of Information Office when your records are ready. A photo ID is required.

Please mail form to:

Medical Records Department
Release of Information Office
2927 Demere Road, Saint Simons Island, GA 31522.

Fax: 912) 634-9890 Attn: Release of Information

If you have any question or concern please feel free to contact me.

Thank you,

LaQuissa Wynn
Director of Medical Records/ Privacy Officer
St. Simon's by the Sea
912-638-1999 x268

SAINT SIMONS
BY-THE-SEA
BEHAVIORAL HEALTH

RELEASE OF INFORMATION

Saint Simons By-the-Sea Hospital
2927 Demere Road
St. Simons Island, GA 31522
Phone: (912) 638-1999
Fax: (912) 634-9890

Patient's Name: _____

Birthdate: _____

Social Security Number: _____

Phone: _____ Fax**:** _____

I authorize Saint Simon's By-the-Sea

To [ ] release to:
To [ ] obtain from:

_____
Name of Person/Facility/Entity

_____
Complete Mailing Address

_____ _____
Phone Number Fax Number

The requested information to be released shall consist of duplicated records concerning the **date(s) of treatment** and/or education on or about: _____

The specific information being requested consists of:
[ ] Discharge Summary [ ] Medical Information [ ] Continuing Care/Discharge Plan [ ] Other_____
[ ] Psychiatric Evaluation [ ] Date of Services Letter [ ] Laboratory Data/EKGs
[ ] Medical History [ ] Complete Medical Record (***Charges Will Apply***)
[ ] Abstract Copy (Consist of: Discharge Summary, Psychiatric Evaluation, History and Physical)

This information is to be used for the purpose of:
[ ] Follow-Up/Continuity of Care [ ] Personal Files [ ] Treatment at Saint Simons By-the-Sea
[ ] Residential Placement [ ] Other

_____

This authorization contains restrictions [ ] YES [ ] NO If yes, please list: _____

_____

This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has already transpired. Specification of date, event, or condition upon which this consent expires is:

_____
If left blank, this consent expires 180 days after discharge, unless this is an insurance request at which time it will expire after insurance benefits have been paid.

I have read and understand the nature of the authorization. I understand that I may revoke it at any time. I release the hospital, its directors, physicians and employees and the above named organization from any and all liability that may arise from this action whether or not foreseen at present. I understand that certain medical records, including any alcohol*, drug abuse information* and HIV, may be protected by Federal Laws and Regulations - *42 U.S.C. 290-3 and 42 U.S.C. 290ee-3 for Federal Law and 42 CFR Part 2 for Federal regulations - but may be included.

The individual for whom this authorization is applies has the right to examine and obtain a copy of the information to be disclosed.

_____ _____ _____
Signature of Patient Date Time

_____ _____ _____
Signature of Parent/Guardian Date Time

_____ _____ _____ _____ _____ _____
Witness Date Time Witness Date Time

VERBAL APPROVAL REQUIRES 2 WITNESSES!