HORIZONS DIAGNOSTICS
Caring for Our Community

MEDICAL RECORDS
Release/Request Form

PH: 706-321-0476, Option 4
Enterprise **FAX:** 706-323-0245
Woodruff **FAX:**706-327-0870

Patient Name (Last, First):		Date of Birth:
Address:		
Are you a current patient at Horizons Diagnostics?	❑ YES ❑ NO	If **YES**, please list your provider:

Please circle and complete the boxes below for either A or B.

A. Request Medical Records **FROM Horizons Diagnostics.**

I authorize Horizons Diagnostics to release health care information to the following recipient(s):

Physician / Name:	Phone:
Address:	Fax:

Delivery Method:
❑ FAX ❑ MAIL ❑ PICK UP

B. Release Medical Records **TO Horizons Diagnostics.**

I authorize the following health care provider to release my medical records to Horizons Diagnostics:

Physician / Name:	Phone:
Address:	Fax:

Delivery Method:
❑ FAX ❑ MAIL ❑ PICK UP

Document Type: If you selected **MAIL** or **PICK UP** for the delivery method, check the box below to determine the document type. NOTE: There may be an additional fee to have records printed.
- ❑ Printed (Paper Copy)
- ❑ Disk/CD

Information to be released or disclosed: I authorize the release/disclosure of the following health information:
- ❑ All
- ❑ Medical History
- ❑ Progress Notes
- ❑ Operative Reports
- ❑ Imaging Reports
- ❑ Laboratory Results
- ❑ Other: _____

Term: I understand that this Authorization will remain in effect:
- ❑ 90 days from the date of this Authorization.
- ❑ Until the Provider fulfills this request.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, behavioral health, AIDS/HIV, or alcohol and drug abuse. I authorize the release or disclosure of this type of information. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above could be redisclosed and no longer protected by those regulations. I understand Horizons Diagnostics may receive compensation for its use/disclosure of the information.
I understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment of my eligible benefits. I voluntarily consent to authorize my health care provider to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified above. I may inspect or copy any information used/disclosed under this authorization. I understand this consent is revocable by me, in writing, at any time except to the extent that action has been in reliance on it.

Patient Signature Date Signature of Witness Date

Signature of Guardian/Representative Date Legal Relationship to Patient Signature of Witness Date