Covenant Community Care

Fax the completed form to Verisma Medical Records Processor at:
678-669-9756

Doctors/Specialists/Health Care providers should request records directly from Covenant Clinic(s) for treatment related purposes.

Dental Records Requests must be submitted to the Dental Clinics directly.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

1) Patient Name: _____ Date of Birth: _____

Social Security #:_____ Maiden/Other Name:_____

Patient Address: _____
Street City State Zip Code

Phone Number: _____

2) Send Medical Records to:

Person/Institution _____

Address _____ City, State, Zip_____

Phone_____ Fax _____

3) **Specific type of information to be disclosed:**

___Discharge Summary	___History & Physical	___Consultations	___Laboratory Results
___X-Ray Report	___X-Ray Films	___Operative Report	___Pathology Report
___Immunizations	___School Physicals	___Complete Medical Record	___Other _____

4) **Dates for requested record**: From ____/_____/_____ To _____/_____/_____

5) **The purpose and need for disclosure** (if applicable): _____

For records pertaining to HIV infection or AIDS, you must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.

I authorize the release of following information contained in my medical record:
YES ____ NO_____ Information about HIV Infection or AIDS, if applicable.
YES ____ NO_____ Information about Substance Use Treatment, if applicable.

***A separate consent form is required to release psychotherapy/behavioral health notes.**

6) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Covenant Community Care. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you have requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

_____ _____ _____
Print Name **Signature of Patient/Personal Representative** **Date**

If you are signing as a parent, guardian or personal representative of the patient, describe this relationship and the source of your authority to sign this form below.

_____ _____
Relationship to Patient **Print Name**