South Central

Primary Care Center, Inc.

"Building a Healthy Community"

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize: South Central Primary Care Center
Location: _____
Fax: (229) 468-9169

To obtain from: _____
(Name of Agency holding the Protected Health Information)

_____
(Address of Agency holding the Protected Health Information)

The following information is to be disclosed:

- ☐ Complete Medical Record
- ☐ Recent Lab/x-ray Reports
- ☐ Health Check
- ☐ Immunization Record
- ☐ Recent Hospital Reports
- ☐ Last 3 Visits
- ☐ PPD or Lead Screen
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Other _____

For the purpose of: Continuation of Medical Care

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive a copy of this authorization**
- **Refuse to sign this authorization and that my treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits may not be contingent on signing this authorization**
- **Revoke this authorization in writing, at any time, but if I do, it will have no effect on any actions taken before the organization received the revocation.**

_____
(Name of Patient) **(Date of Birth)** **(Social Security Number)**

_____
(Signature of Patient or Patient Representative) **(Date)**

_____
(Printed Name or Patient's Representative) **(Date)**

_____
(Witness Signature) **(Title or Relationship)** **(Date)**

South Central Primary Care Center, Inc.
406 W 5TH ST.
OCILLA, GA 31774
PH (229) 468-9166