IRWIN COUNTY HOSPITAL
PALMON GASKINS NURSING HOME
710 N. IRWIN AVE.
OCILLA, GA 31774

Authorization for Release of Information

Request for Transfer of Records to Irwin County Hospital and/or Palemon Gaskins Nursing Home from another Health Care Provider

(Request made by a physician on the medical staff of Irwin County Hospital and/or Palemon Gaskins Nursing Home)

I, _____, hereby authorize

_____ [Name of organization being requested to disclose information] to disclose the following protected health information to **Irwin County Hospital and/or Palemon Gaskins Nursing Home:**

_____

_____

_____

[Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of **Irwin County Hospital and/or Palemon Gaskins Nursing Home** in the following manner:

_____

_____

_____

[Describe how protected health information will be used to carry out treatment, payment and/or health care operations purposes.]

This authorization shall be in force and effect until [specify date] _____

[or specify event] _____ at which time this authorization to use or disclose this protected health information expires.

(over)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: Health Information Management Director
Irwin County Hospital
710 N. Irwin Ave.
Ocilla, GA 31774
229-468-3800

I understand that a revocation is not effective to the extent that Irwin County Hospital and/or Palemon Gaskins Nursing Home has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by Irwin County Hospital and/or Palemon Gaskins Nursing Home and may no longer be protected by federal or state law.

Irwin County Hospital and/or Palemon Gaskins Nursing Home will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority