

Release of Information is managed by ScanSTAT Technologies

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PATIENT INFORMATION:

Last Name		First Name		Date of Birth
Street Address / Apt# (Include Com	plete Mailing Address)		Social Security #
City		State	Zip Code	Telephone Number
PERSON(S) / ORGANIZATIO	N(S) AUTHORIZE	ED TO MAKE DISCLOSU	RE: FAMILY HEALTH	SOURCE
RELEASE AND DISLCOSE I	MY PROTECTED	HEALTH INFORMATION	TO (Recipient of Use	/ Disclosure):
				Fax Number
Street Address / Apt# or Suite (Incl	ude Complete Mailing	Address)		Telephone Number
City		State	Zip Code	Fax Number
DELIVERY METHOD FOR D MAIL PAPER DUPLICATION EMAIL/ELECTRONIC DIGITAL DIGITAL DUPLICATION WILL BE	MAIL CD/DVD DUPLICATION – Plea	DIGITAL DUPLICATION use see page 2 of this release		ER AT <u>http://www.adobe.con</u>
TREATMENT DATE(S) TO BE US	ED/DISCLOSED: F	rom	to	
☐ Consultation(s) ☐ ☐ ☐ ☐ ☐	ecords for personal o	r physician use 🔲 Com	plete Medical Records T DATE(S) PROVIDED:	
This information may include SPECIFIC INFORMATION NOT TO			·	OS information.
THIS INFORMATION IS TO BE US			E(S): (check all that apply)	

MAIL/ELECTRONIC DELIVERY NOTICE: I understand Emails can be intercepted, altered, forwarded, or used without authorization or of stored in both electronic and paper formats. Email addresses can be incorrectly written or type creation and transmission due to technical failure. I understand and accept the risk using an use ScanSTAT Technologies to email me my protected health information when the email delivery involved in using the email delivery method. PLEASE SIGN IF YOU AGREE AND ACKNOW	ed. Emails can be inadvertently exposed, lost during insecure email. I agree for Family Health Source and/or method is chosen and I fully understand the risk					
PLEASE PROVIDE AN EMAIL FOR ELECTRONIC DELIVER	RY					
PLEASE PROVIDE A PREFERED PASSWORD MUST CONTAIN 8 TO 12 (CHARACTERS					
LEAGET ROUBE AT REFERENCE MIGOT CONTAIN OF TO 12 K						
DUPLICATION FEES FOR PATIENTS AND THEIR LEGALLY APPOINTED REPRESENTATIVES (Durable Healthcare Power of Attorney, Parent or Legal Guardian)						
Paper fee for copies of records:						
Pages 1 - 10 =\$ 0.50 per page						
Pages 11+ = \$0.25 per page Fee for electronic duplication of records:						
Email/Digital Images \$14.85 flat fee						
Payment options are: Check, Money Order, Visa, MasterCard or Discover. Please make checks payable to ScanSTAT Technologies. Questions regarding your invoice may be answered at 770-569-2445.						
 Unless withdrawn, this consent will expire 90 days from the date signed unless another By signing this form, I agree to pay any duplication fees or charges for this information If preferred delivery method is unavailable at the time of service, I authorize that this information I understand that the purpose of this authorization is for the use and/or disclosure of my contain information that is protected under state laws and federal regulations. I understable subject to re-disclosure and will no longer be protected by Privacy Protection Rules authorization at any time and that my revocation must be submitted to the Privacy office revocation is not effective to the extent that the persons or organizations in which I have information have acted in reliance upon this authorization. I understand that I may refus not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I authorization upon my signature I hereby authorize Family Health Source and or ScanSTAT Technologies to disclose/rel the course of my diagnosis and/or treatment. I hereby release Family Health Source and may result from this disclosure of confidential medical information or which may arise of information released via mail, fax, and/or electronic delivery. 	on at the time or service or when applicable. ormation to be mailed or faxed. protected health information (PHI) and that it may and that once the above information is disclosed it may. I understand that I have the right to revoke this or at Family Health Source. I understand that my authorized to use and/or disclose my protected health se to sign this authorization and my refusal to sign will I understand that I will be given a copy of this ease medical records and other information obtained in d/or ScanSTAT Technologies from any liability which					
Signature of Patient	Date					
Signature of Personal Representative and Authority to Sign	Date					
Witness	Date					